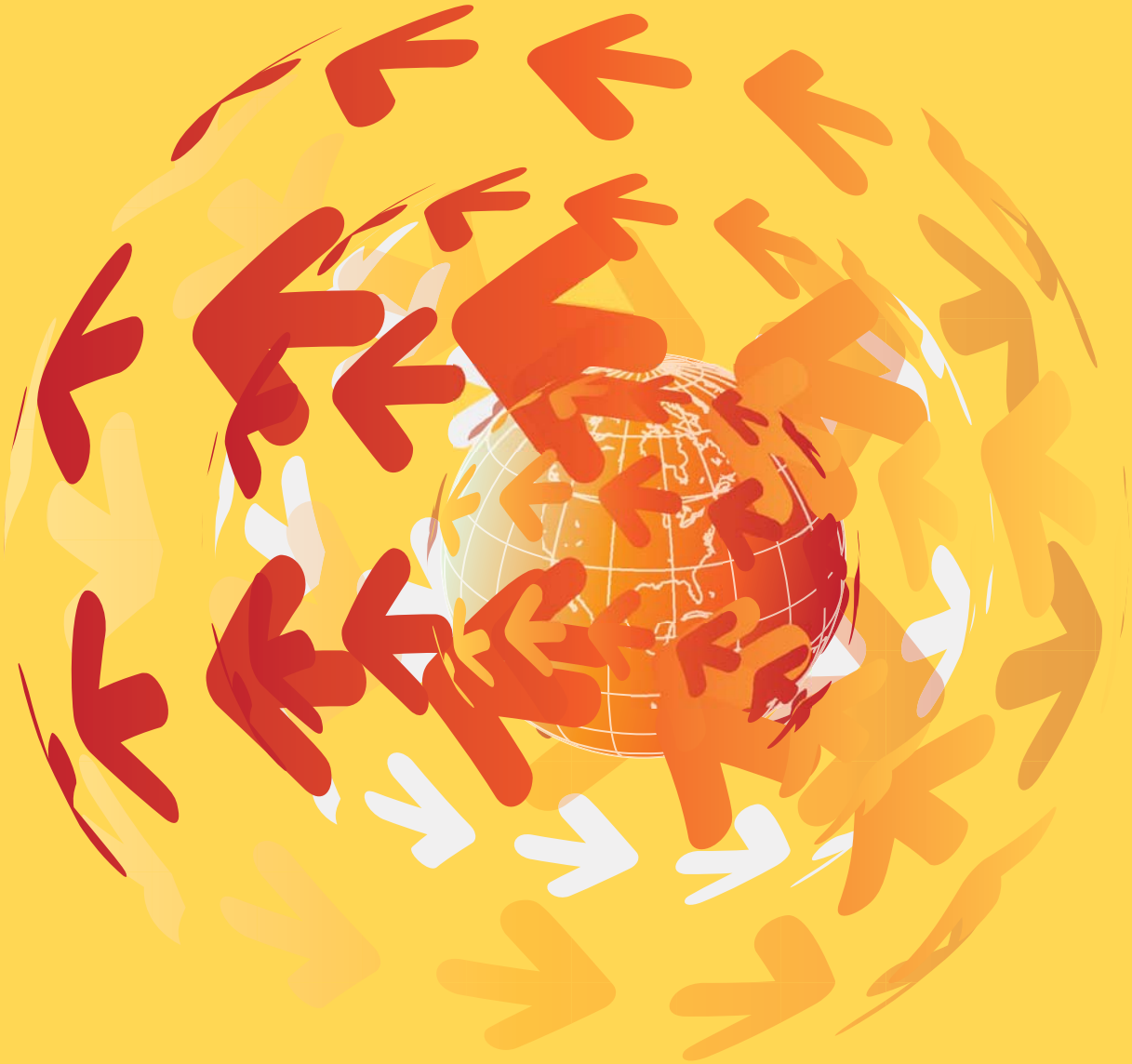
Migration & health

Mexican immigrants in the US: A 10 year perspective



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Migration & Health

Mexican immigrants in the US: A 10 year perspective

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Introduction

This year the *Migration and Health* Report Series celebrates its tenth year in informing policy makers, researchers, and the general public on important migrant health issues in the US. Past reports have focused on access to care, health insurance, health conditions, occupational health and safety, women's health, immigrant children and adolescent's health, the use of services, and health care reform, among others.

Over the past ten years, both public and private entities at the federal, state and local levels have made a number of new policies designed to protect the health of immigrant, Latino and other underserved communities. Most notably, the passage and implementation of the *Affordable Care Act* (ACA) represents a major step towards expanding access to health care. Subsidies for private insurance through the new health benefit exchanges, expanded eligibility for public insurance through *Medicaid*, and increased funding for community health clinics, will significantly increase affordable health insurance and access to services for most previously uninsured legal immigrants. Despite these advances, undocumented immigrants, the majority of whom are Mexicans, will continue to lack health insurance, and new issues such as the migration of unaccompanied minors have surfaced as major health and human rights issues.

The Mexican immigrant population is as important today as it was a decade ago. It has remained relatively stable in size over the past ten years at 4% of the general population (11.8 million people). The US-born population with Mexican ancestry, however, has increased from 16.6 million in 2004 to 22.6 million in 2013, for a combined total of 34.3 million people living in the US who are of Mexican origin. The growth of this group has undeniably contributed to slowing the trend of demographic aging of the US population as a whole. The Mexican origin population has a young age structure, helping to counter the decrease in the working age population in the country. Also, over the past decade, the places that Mexican migrants settle has been slowly spreading throughout the whole of the US, although it is still heavily concentrated in the West and Southwestern states of California and Texas.

Chapter 1 presents general trends of the past decade in immigration to the US, with an emphasis on Mexican and Central Americans. It provides information on their demographic profile as well as their workforce participation, income level and naturalization status as indicators of social integration. Naturalization rates are low and have not changed significantly over the past 10 years. Although all of the groups studied are more likely to live in poverty in 2013 than they were in 2004, Mexican immigrants are more likely to live with low incomes, a fact explained partially by the concentration of Mexican immigrant workers in the low-wage services and industries such as agriculture and construction. And although the total undocumented population in the US has declined slightly over the past ten years, Mexican immigrants continue to account for over 50% of undocumented immigrants. All of these factors are interrelated and are determinants of health and access to health care, revealing that Mexican immigrants are in a vulnerable situation compared with other groups.

Chapter 2 analyzes the changes over time in the health insurance coverage and health service use of the Mexican, Central American, and other immigrant populations in the US compared to US-born popula-

tion groups. The second half of the chapter discusses the access to health care that these groups have experienced. Findings show that Mexican immigrants have the lowest rates of health insurance coverage of all groups and experience the worst access to health care. In both of these areas we anticipate major improvements in the coming years as a result of the advances of the ACA as we describe in this chapter.

Chapter 3 discusses the specific health risk factors of Mexican immigrants, as well as Central American and other immigrant groups in the US, including principal diagnoses and health conditions by group for children under age 18, young people age 12 to 29, adult women and men age 18 to 64, and elderly people age 65 and over. The data show that Mexican immigrants have among the highest rates of obesity and diabetes of all groups, while experiencing lower rates of several other health risks and health conditions.

Chapter 4 presents fertility data for Mexican immigrants and immigrants from Central and South America, as well as US-born groups, over the past 10 years. It also provides mortality and life expectancy data for the entire population of Mexican origin (both US-born and immigrants). It is notable that the fertility of Mexican immigrants has dropped substantially over the past ten years and the life expectancy of the Mexican origin population is the highest of any group.

This report was made possible through a binational effort led by the Mexican Secretariat of Government through the Migration Policy Bureau (UPM) and the National Population Council (CONAPO), in collaboration with the University of California at Berkeley School of Public Health, through the participation of the Health Initiative of the Americas, and the Center for Health Policy Research at the University of California at Los Angeles.

Finally, this report offers conclusions and recommendations for improving the health and social inclusion of the Mexican immigrant population. The health and wellbeing of this population is fundamental to the progress of the United States and Mexico, and is the responsibility of both countries. With Mexican immigrants and their offspring as a fundamental part of the demographic shift that is changing the social and political landscape of the US, their health is crucial to the future and economic progress for both countries.

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Chapter 1
Characteristics of Mexican Immigrants in the United States

Introduction

This chapter provides an overview of the volume and presents the latest data on the trends and characteristics of the Mexican immigrant population living in the United States. It presents data describing their sociodemographic profile, length of residence in the country, rate of naturalization, participation in the labor market and income in order to describe some of the social determinants of health that impact them.

In the United States, social inequality is related to some ethnic-racial migratory factors, so this report uses a comparative perspective to analyze the Mexican population by also presenting data on the US-born population (both non-Hispanic white and African American) and other groups of immigrants (from Central America and other world regions). The analysis is primarily based on the trends of the last decade based on data from the *Current Population Survey* and *American Community Survey* (CPS and ACS), both of which are official US Census Bureau surveys.

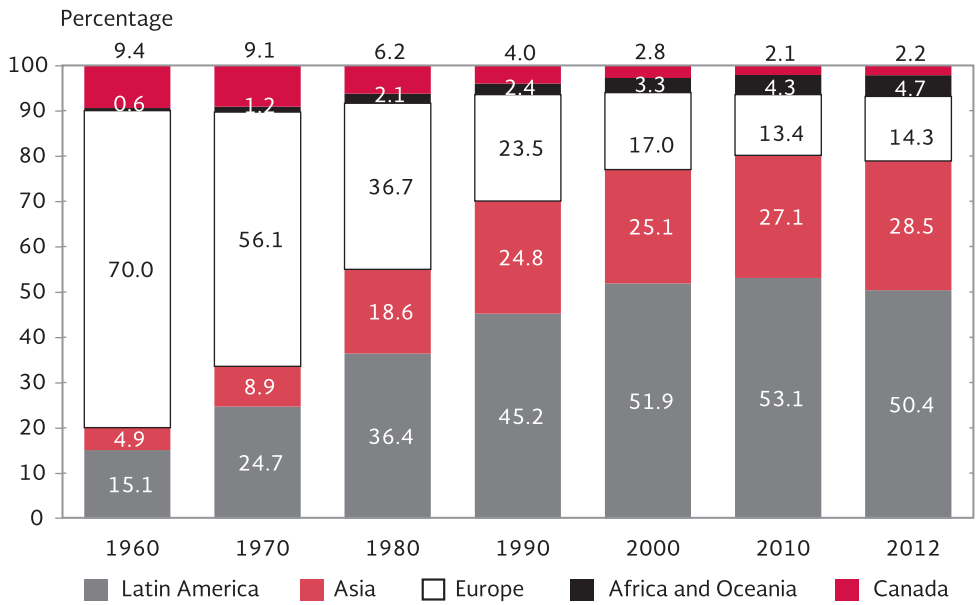
Trends and Scope

Mexicans are the largest immigrant group in the United States

The United States is a country that has been marked by immigration since its birth as a nation. Over the years, numerous and diverse flows of immigrants have contributed to forming the country's identity.

The composition and origin of immigration to the United States has varied dramatically in recent decades. Whereas in 1960, over two out of three immigrants in the United States were Europeans (70%), in the following decades immigrants from Latin America and the Caribbean increased significantly, and from 2000 onwards they accounted for over half of the immigrant population resident in the country (Figure 1).

Figure 1. Distribution of foreign population living in the United States, by region or country of birth, 1960-2012



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *1-percent sample 1960*; *1-percent sample 1970*; *5-percent sample 1980*; *5-percent sample 1990*; *5-percent sample 2000*; *1-percent sample 2010*; *American Community Survey* (ACS), 2012. Minnesota Population Center. Integrated Public Use Microdata Series (IPUMS), Minneapolis: University of Minnesota.

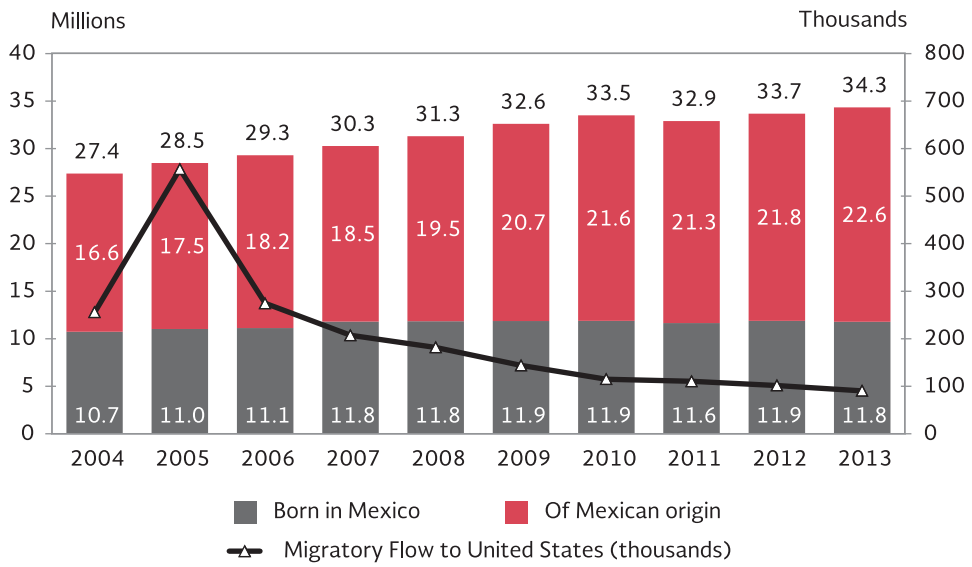
The last three decades of the 20th century saw a considerable increase in the Mexican population living in the United States, which rose from 879,000 in 1970 to 8.1 million in 2000. This doubling in number every 10 years from 1970-2000 rise coincided with changing labor market demand in the US and the implementation of the *Immigration Reform and Control Act* (IRCA) in 1987 that consolidated social networks and facilitated further migration. The subsequent closing of the border forced a progressive abandonment of the circular pattern of labor migration in favor of a more family-based and permanent migration in the United States (Massey, Durand and Malone, 2009).

In 2004, there were already 10.7 million Mexicans living in the United States, and in the next three years the figure reached 11.8 million (almost half of whom were women), a level that has since remained stable. This growth results from the considerable migratory flow reached by the middle of the decade (approximately 200,000 entering from Mexico annually, with a historical peak of 560,000 in 2005). The number of new entrants from Mexico began to drop in 2006 and by 2013 was below 100,000 migrants. The number of Mexican immigrants living in the US dropped between 2010 and 2011 because the number of Mexican immigrants leaving the US exceeded the number of new immigrants entering (Figure 2).

The population of persons born in the US of Mexican descent rose from 16.6 million in 2004 to 22.6 million in 2013, and as a result there are currently an estimated 34.3 million persons of Mexican origin living in the country. Following the worldwide economic crisis that began in 2007, the number of Mexican immigrants living in the United States stabilized, though there was still a gradual increase in the American population of Mexican origin.

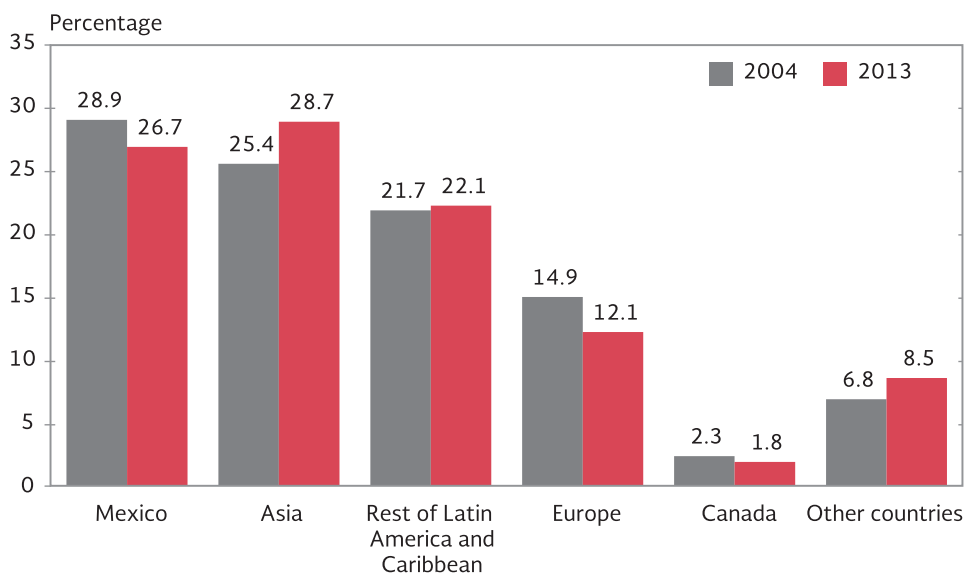
The 11.8 million Mexicans living in the United States in 2013 constituted 4% of the total population of the country, a proportion that has not varied since 2004. Mexicans are thus by far the largest immigrant

Figure 2. Population of Mexican origin living in the United States and migratory flow to the country, 2004-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March from 2004 to 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Figure 3. Distribution of immigrant population in the United States, by region or country of birth, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

group in the United States, with a similar number to that of all immigrants from Asian countries and exceeding that of other Latin Americans and Europeans combined. However, the proportion of all immigrants in the US who were Mexican experienced a slight decrease during that period, from 29 to 27%, while the proportion from Asia increased from 25 to 29% (Figure 3). Meanwhile, the proportion of European population fell by three percentage points, while immigrants from the rest of the American continent remained at approximately 24%.

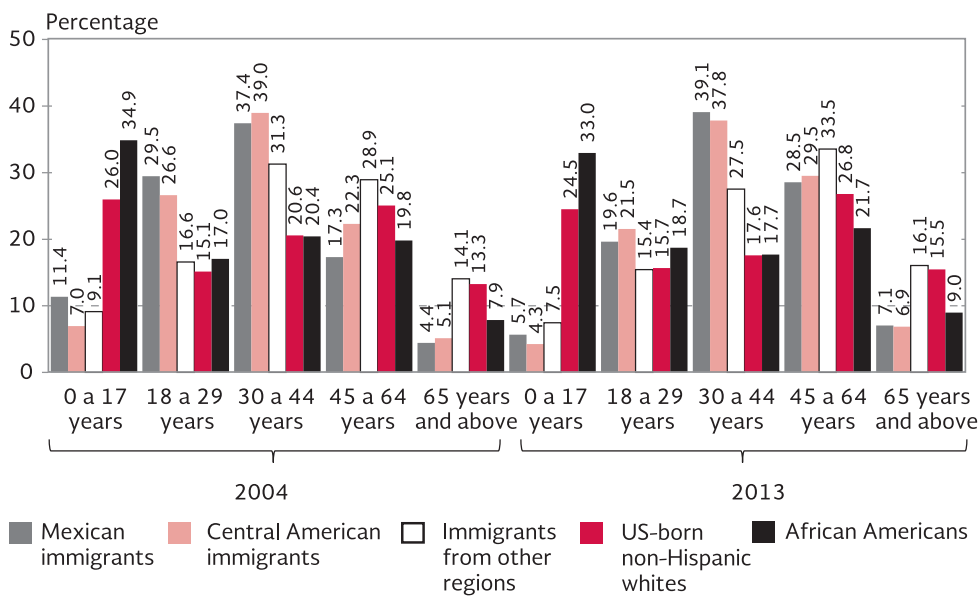
The Mexican migrant population living in the United States is concentrated in working ages

Between 2004 and 2013, the number of under-18 year-olds among the populations considered here decreased, and there has been a simultaneous increase in adults ages 45 to 64 and those over 65.The native populations, both non-Hispanic white and African American, had predominantly young age structures in 2013, with the most common age group being under-18 year-olds (25% and 33%, respectively). In contrast, among immigrant populations the most common age groups are ages 30-44 and 45-64. Among these age groups, the proportion of under-18s decreased and that of older adults increased between 2004 and 2013 in all populations. Among Mexican immigrants, there were more youth (ages 0-17) than older adults (ages 65+) in 2004, a balance which reversed by 2013 (Figure 4).

Demographic aging in the United States

The process of demographic aging in the United States has been taking place for several years and stems from a deceleration in population growth, resulting from a drop in the fertility rate and an increase in life expectancy. Migration has undeniably played a part to the slowdown of this demographic phenomenon. Between 2004 and 2013, the average age of the US population rose from 36 to 37.6 years. Immigrants born

Figure 4. Distribution of United States population, based on region of origin and ethnicity or race, by age group, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

in Mexico, along with those from the second and third generation of Mexican origin, have helped to counter the decrease in the population of working age in the United States, though to a lesser degree than in the two previous decades (Table 1).

Between 2004 and 2013, the total population of working age increased by 13.6 million persons, of which 36% were Mexican and of Mexican origin, a similar percentage to the contribution of all immigrants. Significantly, as reflects the aging of the baby boom generation, the greatest increase in the population occurred among persons between 45 and 64 years old (12.5 million), of whom 18% were of Mexican origin. In contrast, for older adults (65 years and above), US-born non-Hispanic white residents and those from other immigrant regions accounted for approximately 80% of the increase (Table 1).

Geographic distribution of Mexican immigration

The amount of Mexican migration to the United States over the past 40 years has contributed to making their presence throughout the country more visible. Directly linked to the high number of Mexican migrants over recent decades, Mexican migration has spread throughout the whole of the United States. Though California and Texas remain the states with the highest concentration of Mexicans (37% and 22% respectively), the location of migratory flows reveal a gradual variation over time.

According to the data available for 2012, Mexicans account for over 30% of immigrants from all countries in 18 western and south-western states. Over 50% of these immigrants are resident in three of these states, Arizona, New Mexico and Texas, an impressive fact considering that they are merely one immigrant group among many others (Map 1).

The northeast of the United States, in addition to North Dakota and Hawaii, remains the region with the lowest proportion of Mexican immigrants (under 5%), though in 2012 Pennsylvania and New York jointed the 5% to 14% range. Thus the concentration of Mexican immigration is still significantly influenced by proximity to the border with Mexico. These regions have larger communities of Mexicans and more consolidated social networks facilitating migration.

The majority of Mexican immigrants live in US urban centers. In 2012 the metropolitan zones with the highest number of Mexicans are Los Angeles-Long Beach-Anaheim, in California (1.7 million); Chicago-Naperville-Elgin, in Illinois (695,000); Dallas-Fort Worth-Arlington, in Texas (605,000); Houston-The Woodlands-Sugar Land, in Texas (597,000); and Riverside-San Bernardino-Ontario, in California (570,000).

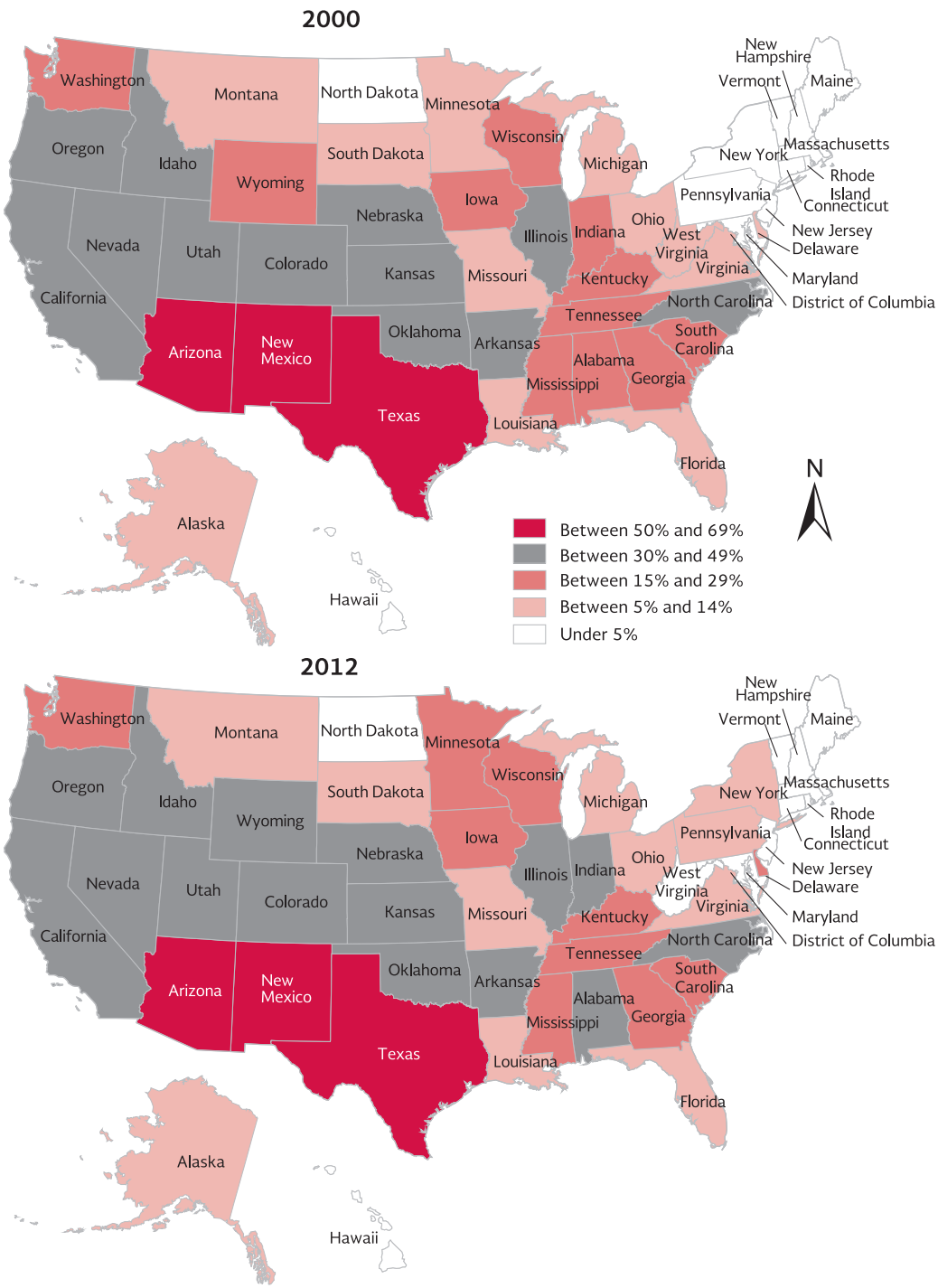
Table 1. Absolute growth of population living in the United States by age group, based on origin and ethnicity or race, 2004-2013

Age group	Total	Foreign and Mexican origin					US-born non-Hispanic whites	African American	Other
		Mexican origin			Central American Countries	Immigrants from other regions			
		Born in Mexico	Second generation[1]	Third or more generation[2]					
Absolute difference (2004-2013)	**22 835 705**	**1 039 230**	**3 701 036**	**3 735 455**	**1 006 039**	**4 820 160**	**2 333 202**	**3 993 138**	**2 207 446**
From 0 to 17 years	606 695	- 553 123	1 495 364	1 941 131	- 18 007	- 43 510	- 3 702 169	474 875	1 012 133
From 18 to 29 years	4 336 588	- 850 182	1 178 914	748 034	102 831	461 102	690 226	1 343 482	662 181
From 30 to 44 years	- 3 230 106	585 344	653 927	298 651	354 454	414 611	- 5 460 718	- 203 399	127 024
From 45 to 64 years	12 494 352	1 503 351	277 174	504 500	458 469	2 731 801	5 198 152	1 597 150	223 754
65 years or above	8 628 176	353 840	95 657	243 138	108 292	1 256 155	5 607 711	781 030	182 354
Contribution to growth (2004-2013)	**100.0**	**4.6**	**16.2**	**16.4**	**4.4**	**21.1**	**10.2**	**17.5**	**9.7**
From 0 to 17 years	100.0	- 91.2	246.5	320.0	- 3.0	- 7.2	- 610.2	78.3	166.8
From 18 to 29 years	100.0	- 19.6	27.2	17.2	2.4	10.6	15.9	31.0	15.3
From 30 to 44 years	100.0	- 18.1	- 20.2	- 9.2	- 11.0	- 12.8	169.1	6.3	- 3.9
From 45 to 64 years	100.0	12.0	2.2	4.0	3.7	21.9	41.6	12.8	1.8
65 years or above	100.0	4.1	1.1	2.8	1.3	14.6	65.0	9.1	2.1

Notes: 1/ Second generation in the United States: Population born in the United States, with one parent born in Mexico.
2/ Third generation or more in the United States: Population born in the United States, whose parents were not born in Mexico, with one parent born in the United States, but who regard themselves as Mexican (Mexico-American, Chicano or Mexican).

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Map 1. Proportion of Mexicans in relation to total immigrants in the United States, 2000 and 2012



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *5-percent sample 2000* and *American Community Survey* (ACS), 2012. Minnesota Population Center. Integrated Public Use Microdata Series (IPUMS), Minneapolis: University of Minnesota.

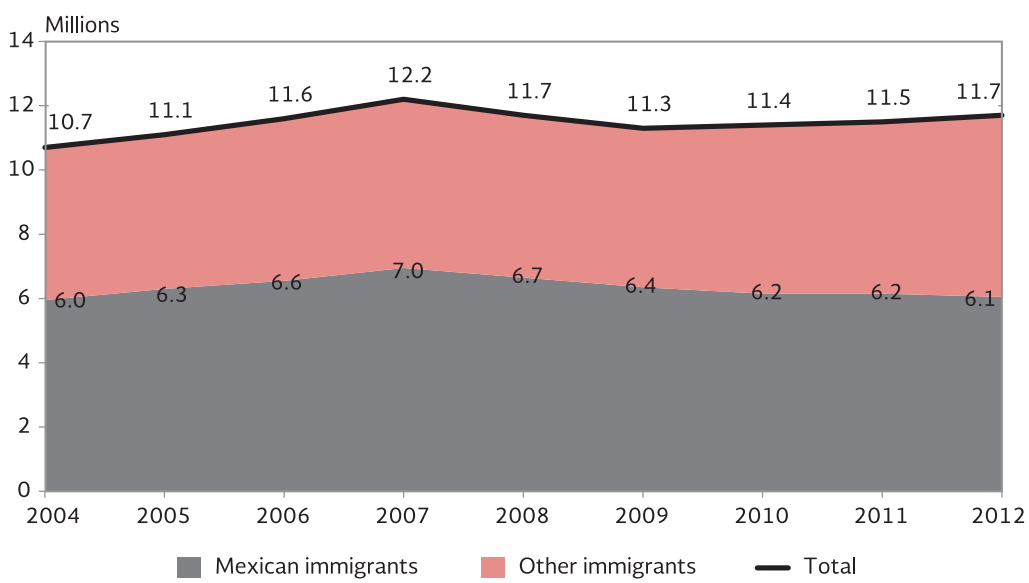
MIGRATORY CONDITIONS

The undocumented population in the United States continues to consist primarily of Mexicans

According to a recent study, there were 11.3 million undocumented immigrants living in the United States in 2013, of which over half were Mexican migrants (52%) (Passel *et al*., 2014; TWH, 2013). Since 2007, the undocumented immigrant population originally from Mexico has decreased from approximately 7 million to 6.1 million in 2012 (Figure 5). The significant reduction of demand for unskilled workers that followed the 2008 economic crisis, which particularly affected the sectors in which Mexicans typically found employment in the country, as well as the difficulties of entering the United States without documents, are reflected in the decrease in the undocumented population living in the country.

American citizenship enables immigrants to exercise their rights and gain access to economic and social benefits. The data available clearly shows that, despite a slight increase between 2004 and 2013, persons born in Mexico and Central America display far lower rates of naturalization than other groups of immigrants. Just over one in four Mexican immigrants have acquired American citizenship (27%), a proportion slightly below that of Central Americans (32%) but significantly lower than that of immigrants from other regions (62%). There is a very low naturalization rate among recently arrived Mexican immigrants (10%), though almost twice that recorded in 2004.[1] In particular, the proportion of Mexicans who have been in the United States for a long period who have become citizens decreased by almost four percentage points during this period (Figure 6).

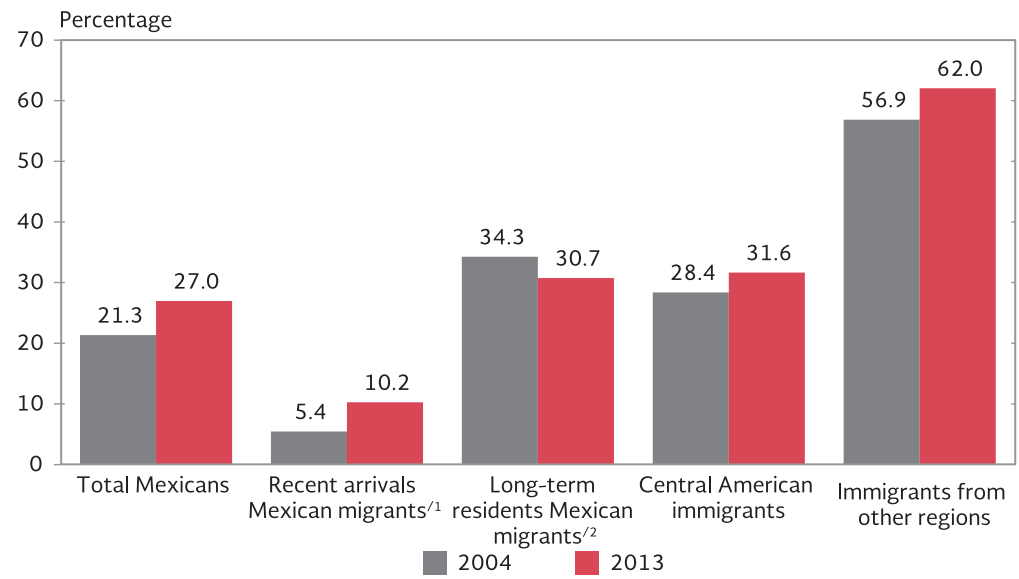
Figure 5. Undocumented immigrant population in the United States, 2004-2012



Source: Passel, J.; D' Vera Cohn; and Ana Gonzalez-Barrera. (2013). *Population Decline of Unauthorized Immigrant Stalls, May Have Reversed*. Pew Research Center. Hispanics Trends Project, September 2013.

[1] Short-term migrants have spent ten years or less living in the United States, while long-term migrants have spent over ten years living in the country, regardless of their immigration status.

Figure 6. Immigrant population in the United States with American citizenship, by region of origin and length of residence of Mexicans, 2004 and 2013



Notes: 1/Recent arrivals: arrived between 1994 and 2004 for 2004; and between 2004 and 2013 for 2013.
2/Long-term residents: arrived before 1994 for 2004; and before 2004 for 2013.
Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Households headed by Mexican and citizenship

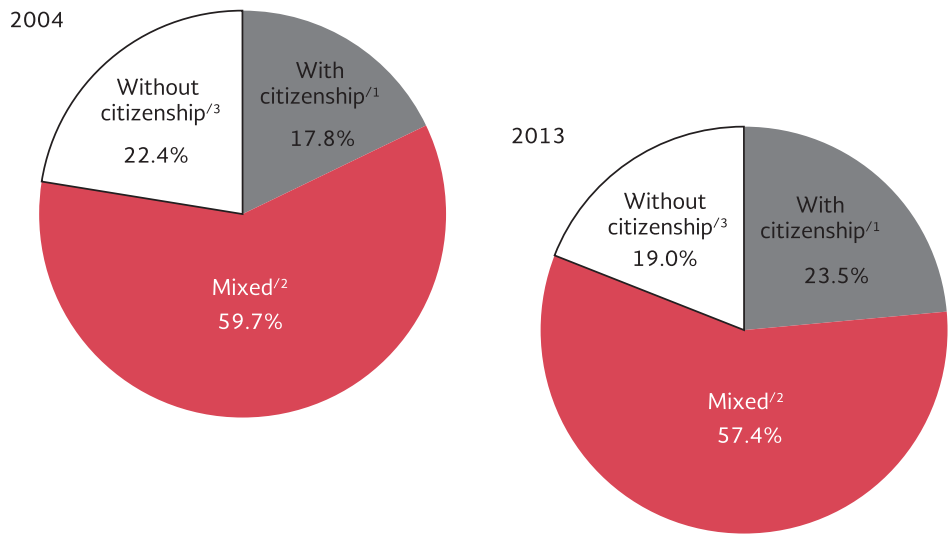
The proportion of households headed by Mexican immigrants with American citizenship reflects the low rate of naturalization among the Mexican population. Although between 2004 and 2013 the proportion of Mexican households in which all members have American nationality rose slightly (by six percentage points), nearly six out of ten households headed by a Mexican immigrant have at least one member with American citizenship and another without it, regardless of the size of the household (Figure 7). The majority of these mixed status households include the children of heads of households who have acquired US nationality as a result of having being born in the country.

MEXICANS CONSTITUTE THE LARGEST GROUP OF IMMIGRANT WORKERS

Mexican migration to the United States is principally for labor purposes and is largely determined by the sharp contrasts in terms of employment and salaries between the two countries. Mexican immigrants contributed approximately 6.7 million persons to the economically active population (EAP) in 2004, which rose to 7.5 million in 2013, making them the largest group of foreign workers.

Like other population groups, Mexicans resident in the United States have a high rate of economic participation (65%), though lower than that of immigrants from Central America (72%), all remaining immigrants (67%) and US-born non-Hispanic whites and only higher than that of African Americans (55%) (Figure 8).

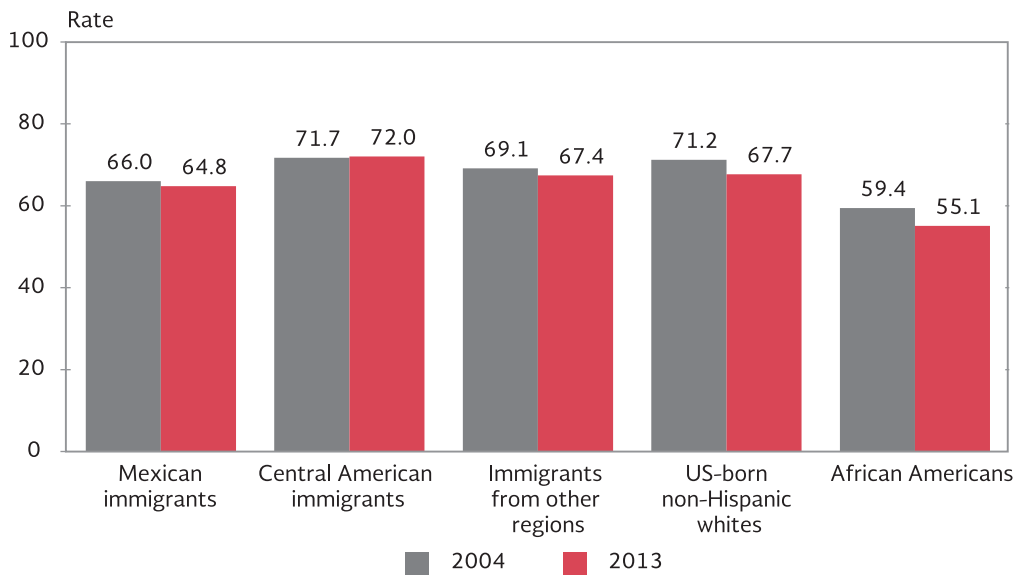
Figure 7. Distribution of households headed by Mexican immigrants living in the United States, by citizenship status of members, 2004 and 2013



Notes: 1/All household members are American citizens.
2/At least one of household member is an American citizen and another is not.
3/No household members is an American citizen.

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Figure 8. Rate of economic participation (percent) of the population[1] in the United States, by region of origin and ethnicity or race, 2004 and 2013



Note: 1/Population between 15 and 64 years old.

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

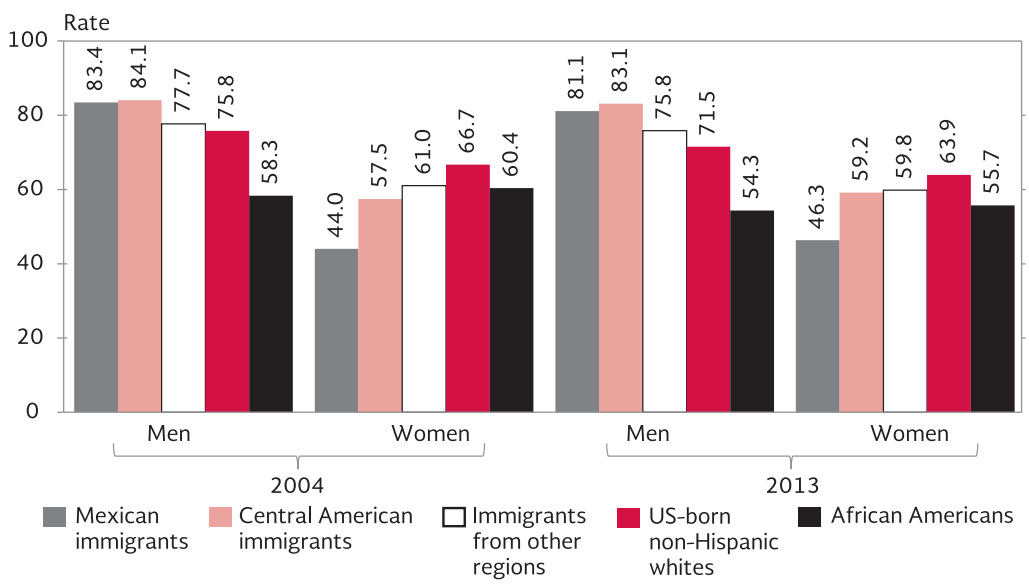
In general, between 2004 and 2013, the rate of economic participation of immigrants resident in the United States fell, with the exception of Central Americans, who even recorded a moderate increase. The decrease in economic participation rates in each group is not statistically significant, with the exception of African Americans, who lost over four percentage points.

An analysis of economic activity by gender shows that the low rate among the Mexican group is explained by the low rate of female economic activity, far below that of their counterparts from other regions of the world and US-born citizens, a situation that has not noticeably changed in recent years. On the other hand, Mexican men display a similar economic participation rate to that of Central American migrants, and a higher rate than other immigrants and US-born non-Hispanic whites and African Americans (Figure 9).

Participation of the migrant population in the productive sectors

The occupation of Mexican immigrants, both in 2004 and 2013, has been concentrated in three categories: seven out of ten are low-income service workers, specialized laborers and construction workers. There are slight differences in the distribution by occupation in comparison with Central Americans, but the largest differences are with immigrants from other regions, as well as US-born non-Hispanic whites and African Americans. US-born non-Hispanic whites and immigrants from other regions have a particularly high concentration in the category of executives, professionals and technicians (Table 2).

Figure 9. Rate of economic participation (percent) of the population[1] of the United States for sex, by region or origin and ethnicity or race, 2004 and 2013



Note: 1/Population between 15 and 64 years old.
Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Table 2. Distribution of the immigrant population working in the United States, by type of occupation in the country, based on origin and ethnicity or race, 2004 and 2013

Occupation	Total Mexican immigrants	Mexican immigrants		Central American immigrants	Immigrants from other regions	US-born non-Hispanic whites	African Americans
		Recent arrivals migrants[1]	Long-term residents migrants[2]				
2004							
Total population[3]	**6 155 854**	**2 504 553**	**3 651 301**	**1 448 845**	**13 279 614**	**95 057 055**	**12 783 540**
Total distribution	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Low-income service workers	26.8	32.9	22.6	29.4	14.4	10.0	15.4
Specialized laborers[4]	28.9	24.7	31.8	24.8	15.6	15.6	19.5
Construction workers	18.7	23.2	15.5	16.0	4.2	5.4	3.3
Sales, administrative support and office work	12.2	9.3	14.2	15.0	23.0	26.9	26.7
Executives, Professionals and Technicians	7.6	5.1	9.4	11.1	37.9	37.9	27.0
Farmers and agricultural workers	4.3	4.3	4.3	1.0 *	0.2 *	0.5	0.3 *
Semi-qualified service workers	1.5	0.5 *	2.3	2.7 *	4.7	3.7	7.8
2013							
Total population[3]	**6 819 926**	**1 197 617**	**5 622 310**	**2 110 595**	**15 330 065**	**92 866 435**	**13 470 438**
Total distribution	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Low-income service workers	29.8	35.4	28.6	34.9	15.3	11.2	15.1
Specialized laborers[4]	25.6	22.3	26.3	21.1	13.8	14.5	18.0
Construction workers	16.5	17.6	16.3	13.6	3.3	4.3	2.1
Sales, administrative support and office work	12.0	9.0	12.7	14.4	19.4	24.3	27.1
Executives, Professionals and Technicians	10.2	8.4	10.6	11.5	42.8	41.0	28.5
Farmers and agricultural workers	4.1	6.9	3.5	2.4	0.3	0.5	0.4
Semi-qualified service workers	1.7	0.6 *	1.9	2.1 *	5.1	4.3	8.8

Notes: 1/ Recent arrivals: arrived between 1994 and 2004 for 2004; and between 2004 and 2013 for 2013.
2/ Long-term residents: arrived before 1994 for 2004; and before 2004 for 2013.
3/ Population between 15 and 64 years old, excluding members of the armed forces and person with non-specified occupation.
4/ Excludes construction workers
* Less than thirty sample cases.

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

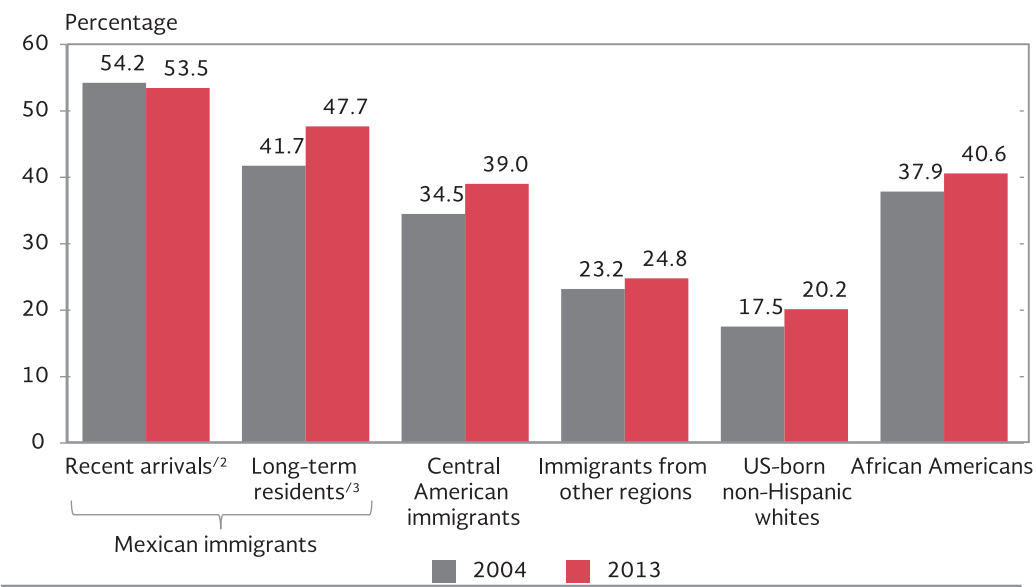
Among Mexican migrants, the duration of the migratory experience tends to improve access to better employment moderately, as long-term migrants present a higher concentration in categories such as specialized laborers or workers, salespersons and executives then more recent migrants. The most notable change is the drop in the percentage of construction workers among recent arrivals (a decrease of over five percentage points between 2004 and 2013), linked to the mortgage crisis and slowdown in the construction industry.

While Central American immigrants are concentrated in the same labor groups as Mexican immigrants, their proportion in the categories of executives, professionals, technicians, sales, administrative support and office workers is higher than that of those born in Mexico.

Low-incomes are frequent among the Mexican immigrant population

In the United States, the population living in poverty has increased among all the groups studied in the past decade. A comparison of the percentages of immigrants, US-born non-Hispanic whites and African Americans living below 150% of the federal poverty line for the United States shows that Mexican immigrants are the group with the greatest economic deprivation, both in 2004 and 2013 (Figure 10), and that this situation is most severe among recent arrivals. Factors such as the lack of documentation and the sectors of activity in which Mexicans are concentrated (low paid and heavily penalized by the economic crisis) have contributed significantly to the economic deprivation of the Mexican population in the United States.

Figure 10. Low-income population[1] in the United States, by region of origin and ethnicity or race, 2004 and 2013



Notes: 1/Income under 150% of the federal poverty line for the United States.
2/Recent arrivals: arrived between 1994 and 2004 for 2004; and between 2004 and 2013 for 2013.
3/Long-term residents: arrived before 1994 for 2004; and before 2004 for 2013.

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Importantly, there has been a worrying increase of six percentage points in long-term Mexican migrants earning low incomes, which demonstrates the difficulties entailed in the migratory experience during the past decade and the relative decline of social conditions of Mexicans in the United States.

After Mexicans, African Americans have the second highest proportion of persons with an insufficient income, with an increase of two percentage points between 2004 and 2013, followed by Central American immigrants, with a rise of four percentage points.

Conclusion

Although the composition and origin of immigration to the United States has changed significantly in recent decades, Mexicans are still the largest population group in the United States. The high immigration rates of Mexicans in the past forty years mean that they have been distributed throughout the United States, mainly in urban areas, and traditional destination states.

Mexican residents are predominantly ages 18 to 64, which has helped offset the decline in the working age population in the United States, although less so than in the previous two decades. Mexican immigrants, mainly located at the base of the labor pyramid, constitute the largest group of foreign workers.

Immigration status determines the exercise of rights and access to economic and social benefits. Mexicans also face disproportionately severe handicaps linked to their undocumented situation, which deprives them of obtaining documented residence and the acquisition of citizenship, which impacts the households they head and the provision of rights and opportunities for their members.

Chapter II
Access to Health Insurance and Service Use

Introduction

Mexican immigrants in the United States face considerable difficulties in receiving health care, which can have a negative effect on their physical and emotional health. The exclusion of a considerable segment of this population from health insurance coverage reflects their disadvantage in terms of labor and social integration, and limits their ability to use health care services appropriately.

The *Patient Protection and Affordable Care Act* (ACA), whose major provisions took effect in 2014, is expected to increase the number of Mexican immigrants with health insurance coverage. However, given that over half of those with undocumented status are Mexican, a significant segment will remain excluded (see box I). This chapter compares immigrant populations from Mexico, Central America and other regions with US-born whites and African Americans, and highlights the differences in terms of health insurance coverage and use of health services. It also explores the relationships between coverage and the different situations directly linked to the migrant experience, such as length of stay and citizenship status. It also shows the disadvantages faced by Mexican and Central American migrants to receiving timely health care in the United States.

The analysis compares the situation in 2004 with that in 2013, based on data from the *Current Population Survey* (CPS) and the *National Health Interview Survey* (NHIS).[1] The impact of the implementation of the ACA will be reflected in the results of surveys undertaken after 2013.

Coverage and type of health insurance

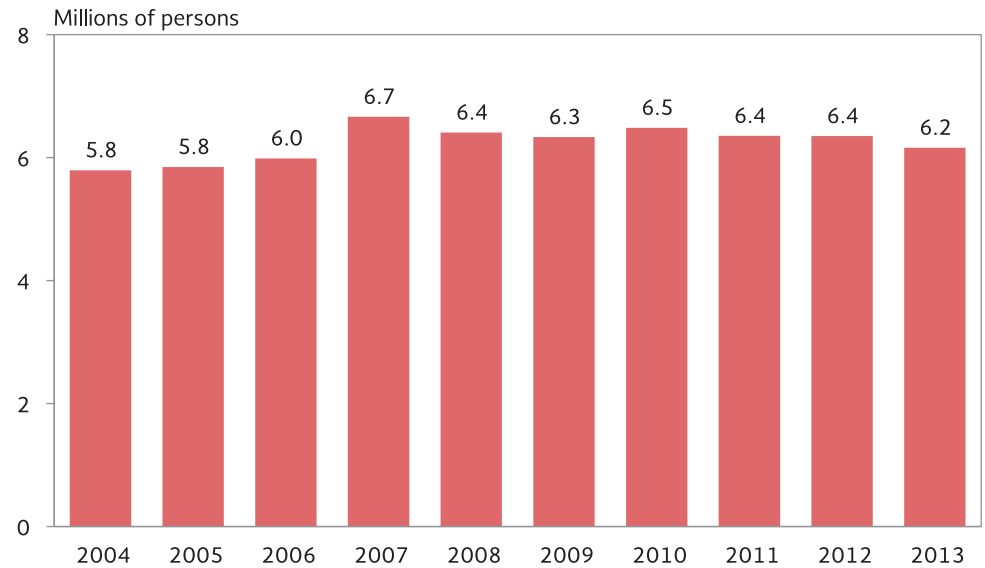
Approximately 6.2 million Mexican immigrants lack health insurance

Mexican immigrants face a series of obstacles that restrict their access to a wide array of services for the prevention, diagnosis, treatment and rehabilitation of illnesses. This has negative consequences for their health, both physical and mental, and exacerbates their marginalized condition in the United States.

In 2013, approximately 6.2 million Mexican immigrants were living in the United States without health insurance, a figure that has decreased since 2007, likely due to the decrease in the undocumented population (Figure 11).

[1] Given the limitations of the NHIS sample size, which prevent stable estimates for a single year, the periods 2004-2005 and 2012-2013 were analyzed.

Figure 11. Mexican population living in the United States without health insurance, 2004-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 to 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

The proportion of Mexicans without health insurance in the United States is greater than that of other groups

Although Mexicans represented almost 4% of the US population in 2013, they account for 13% of the population without health insurance. Mexicans clearly constitute the most excluded group, in comparison with immigrants from other regions, US-born whites and African Americans. In 2013, just over half (52%) of Mexicans were uninsured, three times higher than the proportion for African Americans (17%), four times higher than that of non-Hispanic US-born whites (12%) and two and a half times higher than that of the remaining immigrants (20%). Central Americans report a slightly lower percentage than Mexicans (49%) (Figure 12).

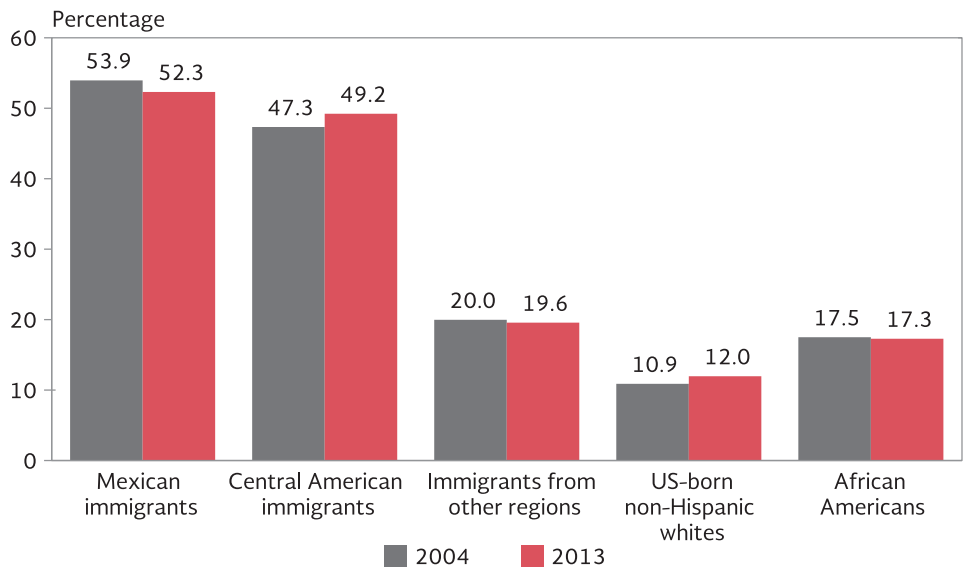
These figures reveal inequality in access to health care in the United States based on race, ethnicity and region of origin, a situation that has remained virtually the same between 2004 and 2013.

Over six out of ten recently-arrived Mexican and Central American immigrants do not have health insurance

The proportion of the population without health insurance is greatest among recent arrivals from all regions, showing that length of residence in the receiving society is a favorable factor for the social integration processes of immigrant populations. Long-term immigrants tend to have employment with higher salaries and better work benefits, such as health insurance, due both to their acquisition of skills and competencies and to their improved knowledge of the labor market and social systems. However, Mexican and Central American levels of vulnerability are still much higher than that of migrants from other regions, both among the recently arrived and those with long stays (Figure 13).

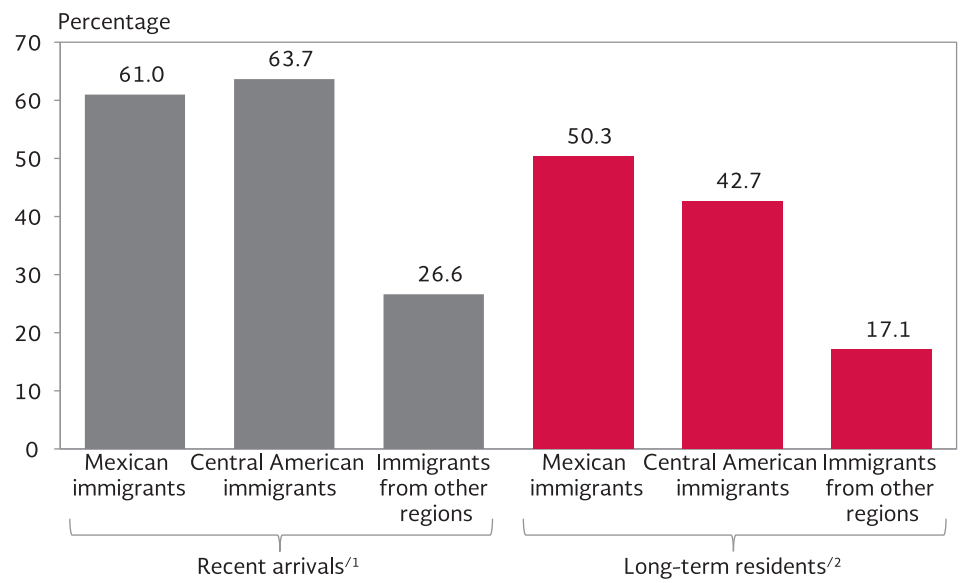
Recent arrivals from Central America have the highest percentage of population without health insurance coverage (64%), followed by Mexicans (61%) and, to a lesser extent, people from other

Figure 12. Population of United States without health insurance, by region of origin and ethnicity or race, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Figure 13. Immigrant population in the United States without health insurance, by period of arrival in the country, based on region of origin, 2013



Notes: 1/Recent arrivals: under 10 years in the USA.
2/Long-term residents: 10 years or more in the USA.

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), from March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

regions (27%). The improvement in health insurance coverage for long-term immigrants is ten percentage points among Mexican, 21 percentage points among Central Americans and under ten percent among other immigrants, though the latter group has better living conditions, regardless of their length of residence in the United States.

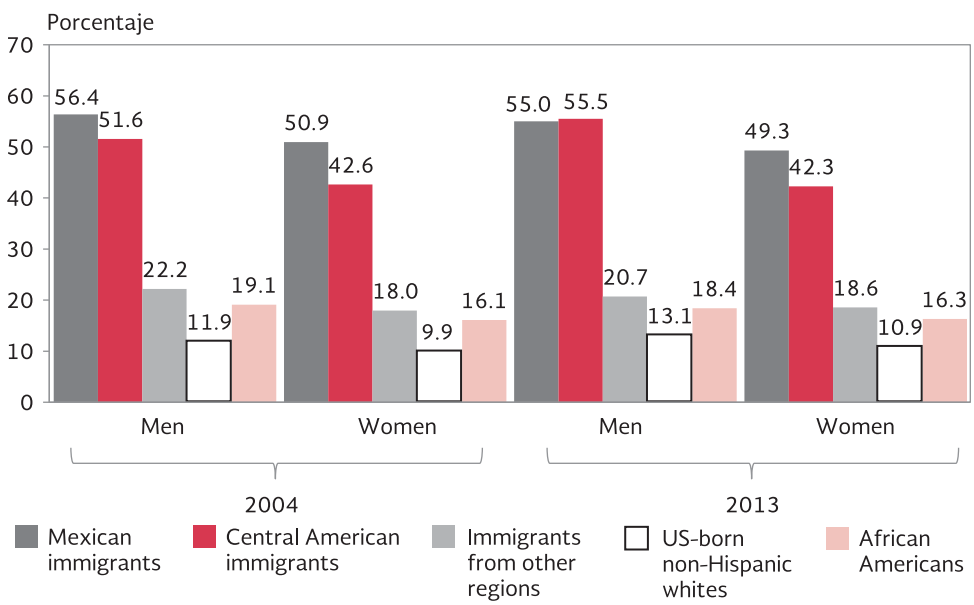
Mexican immigrant women are more likely to have health insurance than men

There is also inequality in the distribution of health insurance coverage by gender, since out of the five groups studied here, men record higher percentages of exclusion from health insurance coverage than women, though these disparities are higher among Central American and Mexican immigrants (56% and 42% in the first case, and 55% and 49% in the second, in 2013). However, in the Mexican population, no significant changes occurred from one period to another. Among Central Americans the gender gap in uninsurance was the largest of any group and widened from nine percentage points in 2004 to 13 percentage points in 2013 (Figure 14).

The lack of health insurance among Mexican immigrants is accentuated in the 18 to 29 year age group

An analysis of health insurance coverage by age group shows the disadvantage faced by Mexicans and Central Americans at the various stages of the life cycle.

Figure 14. Population of United States without health insurance, by region of origin and ethnicity or race, based on gender, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

According to the most recent figures for Mexican immigrants, in 2013 four out of ten children, almost two out of every three young people ages 18 to 29, six out of ten adults ages 30 to 44 and half of adults ages 45 to 64 lacked health insurance. The proportion of Central Americans without health insurance coverage is only lower among children and adolescents (22%) and adults ages 45 to 64 (41%). Both Mexican and Central American immigrants' rates are more than double that of other immigrants and higher than those of non-Hispanic US-born whites and African Americans. Moreover, 10% of Mexicans over age 65 do not have health insurance, higher than the figure recorded for other immigrant groups and natives (Figure 15). Without insurance they are less likely to seek timely and adequate care for health problems such as the chronic illnesses that are most common during that stage of life.

Between 2004 and 2013, the lack of health insurance coverage decreased among young age groups in the population, with the exception of non-Hispanic US-born whites ages 18 to 29. The main changes were recorded among Mexican immigrant children (approximately 13 percentage points less) and Central Americans (18 percentage points less).

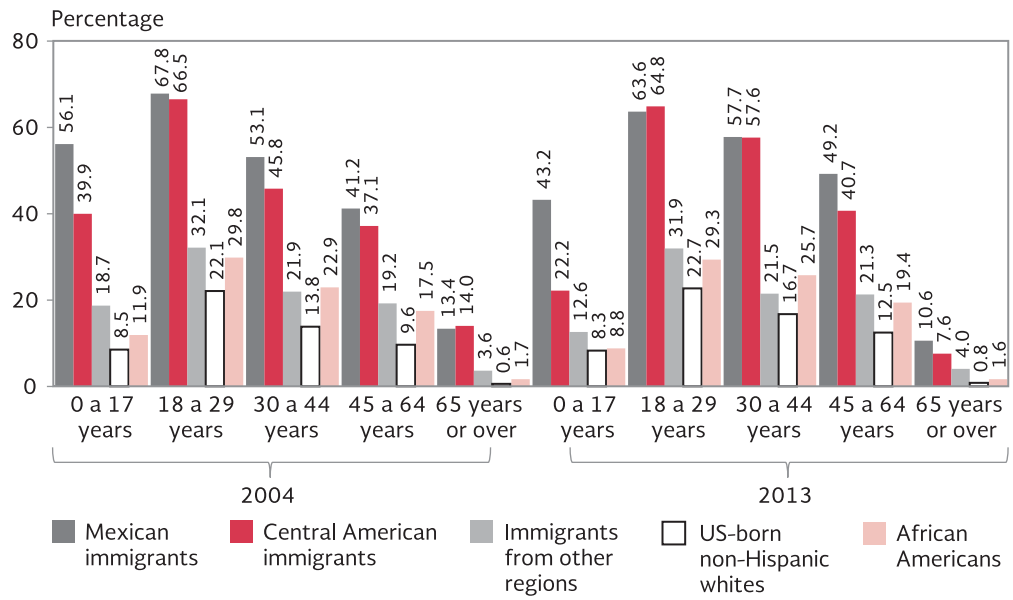
In contrast, the prevailing trend among the adult populations is a decrease in the availability of health insurance, in particular among Central Americans ages 30 to 44 (12 percentage points) and Mexicans ages 45 to 64 (8 percentage points). Finally, among older adults there has been a slight decrease in the number of Central American immigrants without health insurance (almost seven percentage points) (Figure 15).

Lack of health insurance coverage is increasing among Mexican immigrants without American citizenship

Citizenship is an important indicator of social integration among immigrant populations and is related to labor and social rights, including health insurance. Among the three groups of immigrants studied, the proportion of citizens without coverage is significantly lower than that of non-citizens, both in 2004 and 2013. However, even with similar citizenship status, immigrants from Mexico are more likely to lack protection than those from Central America and other regions (32%, 22% and 15%, respectively), which is closely linked to their greater concentration in employment that provides limited or no employment benefits.

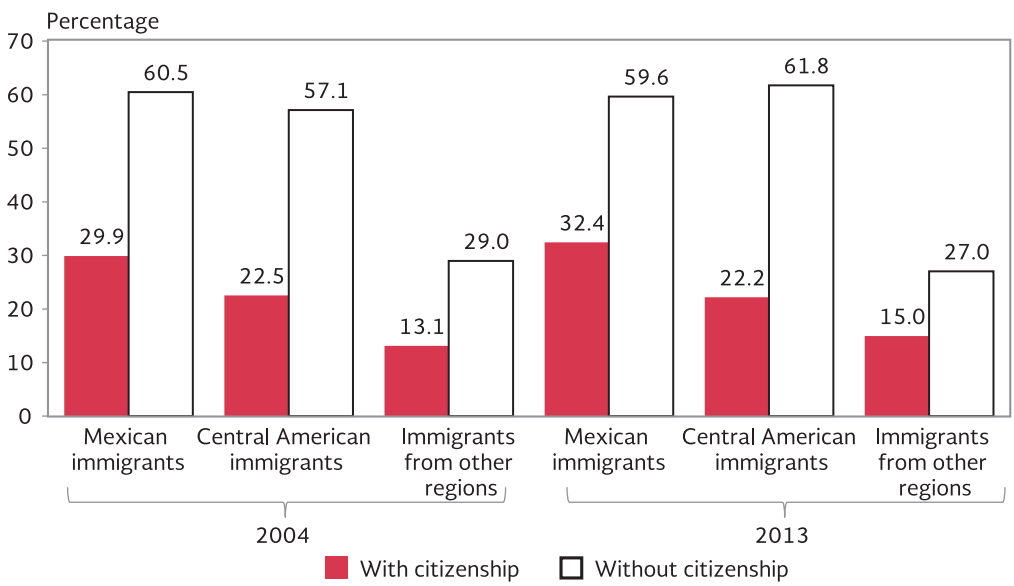
The situation of Mexican and Central American immigrants without citizenship, many of whom are undocumented and working in low-wage or unskilled jobs without access to public programs (PHS, 2009), is more problematic. Indeed, approximately six out of ten noncitizens do not have health insurance, a figure that remained unchanged between 2004 and 2013 (Figure 16).

Figure 15. Population of United States without health insurance, by region of origin and ethnicity or race, based on age group, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Figure 16. Immigrant population in the United States without health insurance, by American citizenship status, based on region of origin, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and March 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

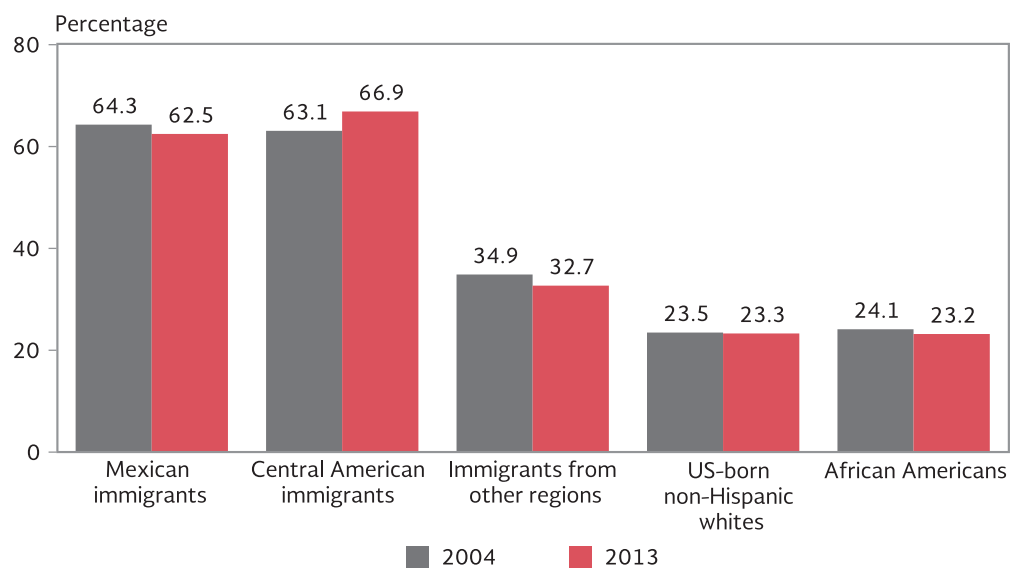
Mexican immigrants with low incomes are more likely to lack health insurance

Mexican and Central American immigrants with low incomes are the groups most lacking in health insurance coverage: over six out of ten are uninsured. This is over twice the proportion of immigrants from other regions and three times that of non-Hispanic US-born whites and African Americans. This disadvantage among low-wage Mexican and Central American immigrants has remained stable during the period analyzed (Figure 17). In a context of economic precariousness and exclusion from the health care system, these low wage immigrants will face severe barriers to obtaining health services when they need it.

Construction workers are the Mexican immigrants with the least protection

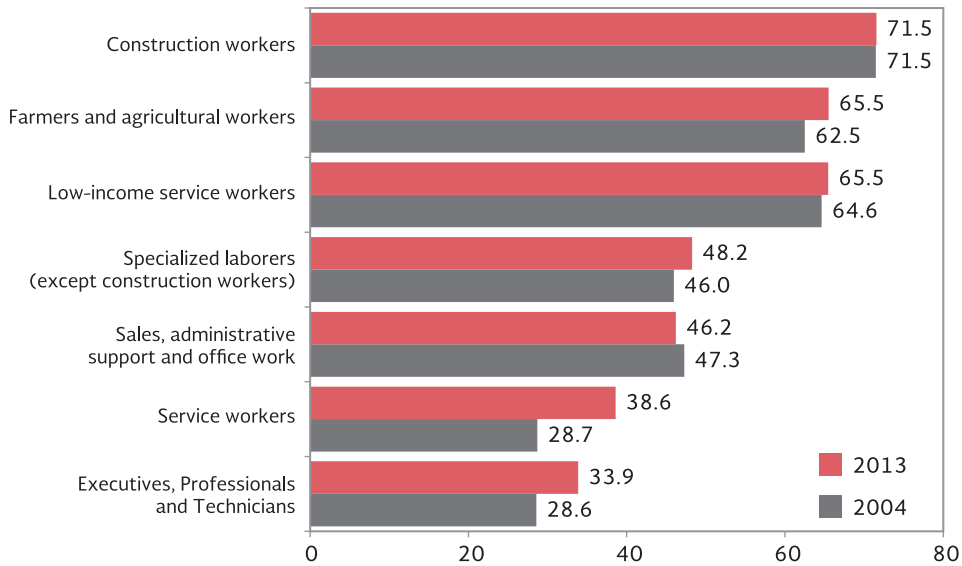
Employment in construction, agriculture and unskilled services, sectors which employ Mexican immigrants at a high rate, is related to lack of protection in terms of health insurance coverage. Indeed, 72% of Mexican construction workers and 66% of those engaged in agriculture and unskilled service jobs do not have health insurance, according to data for 2013 (Figure 18). This is alarming, as figures from the Department of Labor of the United States show that the construction sector had the highest number of fatal accidents in 2012, while agriculture, forestry, fishing and hunting showed the highest rate of non-fatal work acci-

Figure 17. Low-income population[1] in the United States without health insurance by region of origin and ethnicity or race, 2004 and 2013



Note: 1/Income under 150% of the federal poverty line for the United States.
Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Figure 18. Mexican population living in the United States without health insurance, by occupation, 2004 and 2013



Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

dents in the same year (BLS, 2014). Importantly, the occupations with the greatest increase in uninsured workers between 2004 and 2013 are service jobs and executives, professionals and technicians (ten and five percentage points, respectively).

Over half of Mexicans lack health insurance in eight out of the ten states with the highest number of Mexican immigrants

There are significant differences at the state level in terms of the degree of exclusion of Mexican immigrants from access to health insurance, which has been affected by the implementation or absence of economic, social and cultural policies within local and state governments. In 2013, the states of North Carolina, Maryland, Florida and New Jersey recorded the highest uninsured rates (between 78 and 70%). In five states (Kansas, Georgia, Oregon, Idaho and Texas), between 60 and 70% of the Mexican immigrant population lacked insurance, and between 50 and 60% were uninsured in eight other states (Utah, New York, Wisconsin, Washington, Nevada, Colorado, New Mexico and Arizona). In the states with the largest numbers of Mexican immigrants, only in California and Illinois did less than half lack health insurance (43% and 40%, respectively). Kansas and Georgia increased their percentages between 2004 and 2013, 23.8% and 10.3%, respectively (Table 3).

Table 3. Proportion of the Mexican immigrant population living in the United States without health insurance, by selected US States, 2004 and 2013

State of residence	Year	
	2004	2013
US total	**53.9**	**52.3**
North Carolina	74.5	77.5
Maryland	78.1	73.0
Florida	64.4	71.5
New Jersey	73.6	70.2
Kansas	45.1	68.9
Georgia	55.8	66.2
Oregon	70.4	65.5
Idaho	77.9	65.1
Texas	59.7	63.5
Utah	53.7	58.9
New York	75.7	57.9
Wisconsin	69.5	56.1
Washington	71.2	53.5
Nevada	47.8	52.9
Colorado	60.4	52.7
New Mexico	46.1	52.5
Arizona	46.6	51.6
Nebraska	41.8	47.1
Delaware	57.9	42.8
California	46.3	42.5
Illinois	45.5	40.3

Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Type of health insurance

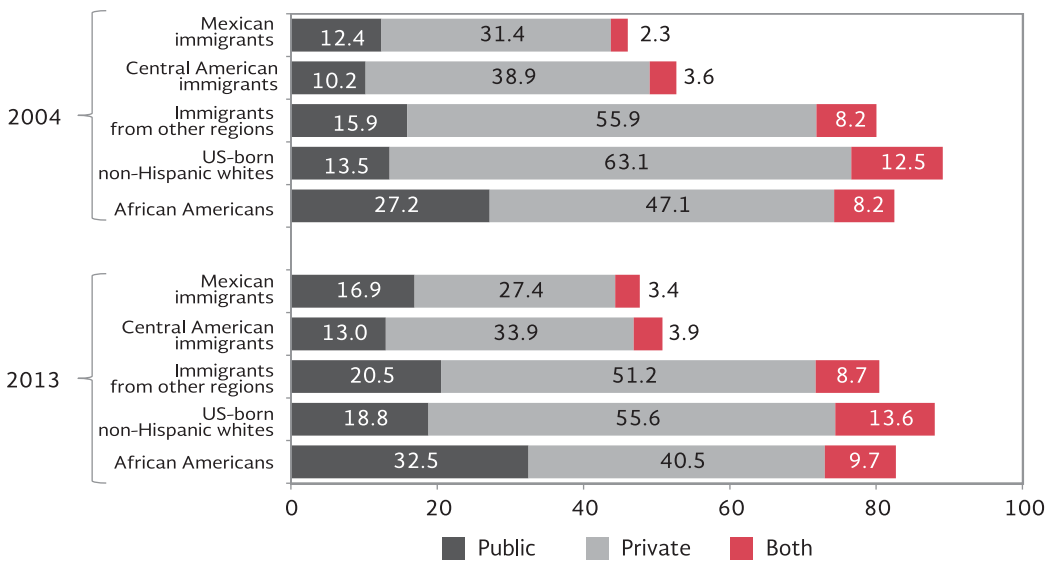
Mexican immigrants have the lowest rates of coverage through private health insurance

The health care system in the United States is mainly based on private insurance, usually obtained through employment (one's own or that of a relative), whereas public insurance covers a minority, as it is targeted at those with the lowest incomes (*Medicaid*) and the elderly (*Medicare*).

These programs undeniably provide medical security to a significant number of low-income individuals and families in the United States. However, low-income immigrants, particularly those who are undocumented, face significant obstacles to obtaining public health insurance.

In 2013, the majority of the insured population was covered by a private policy (exclusively or combined with a public policy) in the five groups analyzed. Mexican and Central American immigrants had the lowest rates of private health insurance (31% and 38%, respectively), followed by African Americans (50%). On the other hand, 69% of non-Hispanic US-born whites and 60% of other immigrants had private insurance (Figure 19). These inequalities in private health care coverage reveal a racial/ethnic stratification of the labor market in the United States, whereby the former two groups have a greater presence in occupations with limited working benefits, while the latter two are concentrated in jobs that often provide these benefits.

Figure 19. Population of the United States with health insurance, by type of Insurance, based on region of origin and ethnicity or race, 2004 and 2013

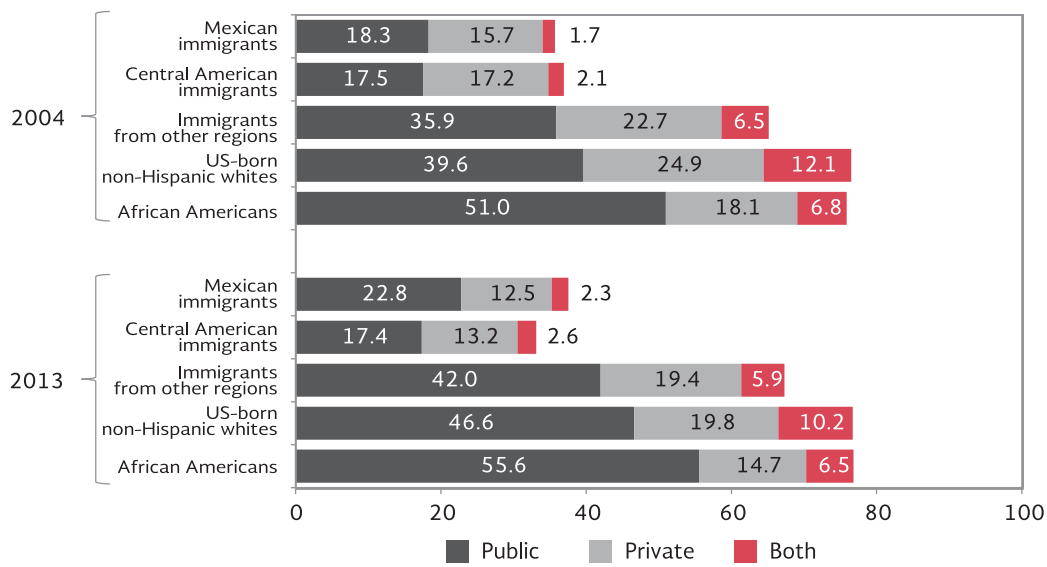


Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

Low-income Mexican and Central American immigrants have lower percentages of public health insurance

Approximately half of Mexican immigrants who lack health insurance live in low-income families. However, like their Central American counterparts, their access to public programs targeted at the most vulnerable groups is extremely limited. Indeed, in 2004 only one in five low-income Mexican immigrants benefited from these programs (exclusively or combined with private insurance), while in 2013 this rose to one in four. On the other hand, African American, US-born non-Hispanic whites and immigrants from other regions had greater access to these programs (Figure 20). The increases in public coverage between 2004 and 2013 for most groups, except Central Americans, was likely due to the efforts of many states to increase coverage of low-income and immigrant children made possible by the *Children's Health Insurance Program Reauthorization Act* (CHIPRA) of 2009 (Saloner *et al*., 2014).

Figure 20. Low-income population[1] of the United States with health insurance, by type of Insurance, based on region of origin and ethnicity or race, 2004 and 2013



Note: 1/Income under 150% of the federal poverty line for the United States.
Source: Migration Policy Bureau, SEGOB, based on U.S. Census Bureau, *Current Population Survey* (CPS), for March 2004 and 2013. Integrated Public Use Microdata Series (IPUMS) USA, Minneapolis: University of Minnesota.

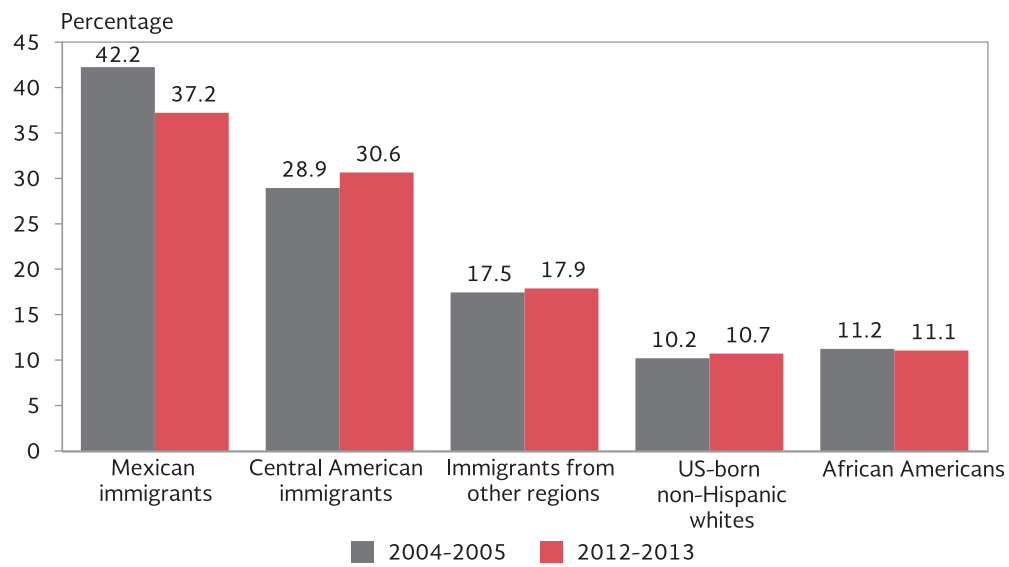
Use of health services

Mexican immigrants frequently have no usual source of health care

The data presented in the previous section show that Mexican immigrants in the United States, followed by Central Americans, were more vulnerable and less protected in terms of health insurance, a situation that has not improved significantly in the past decade. Health insurance enables people to access health care more regularly and in a more timely manner. On the other hand, the lack of coverage among a large segment of the low-income population is the main obstacle to regular health care. In addition to financial barriers, there are additional cultural, linguistic and legal difficulties in obtaining access to medical care for immigrant populations.

It is crucial to have a usual source of care to ensure consistent check-ups, to prevent illness and for the timely diagnosis and treatment in the event of illness or emergency. Compared to other groups, Mexican immigrants are much less likely to have a usual source of health care in the United States, which stems directly from their lower health insurance coverage, among other factors. Though the proportion of Mexicans without a usual place for health care decreased from 42% to 37% between 2004 and 2013, this figure is still higher than that of Central Americans (31%), twice as high as that of immigrants from other regions (18%) and three times as high as that of non-Hispanic US-born whites and African Americans (11% in both cases) (Figure 21).

Figure 21. Population of United States without regular source of care, by region of origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview* Survey (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

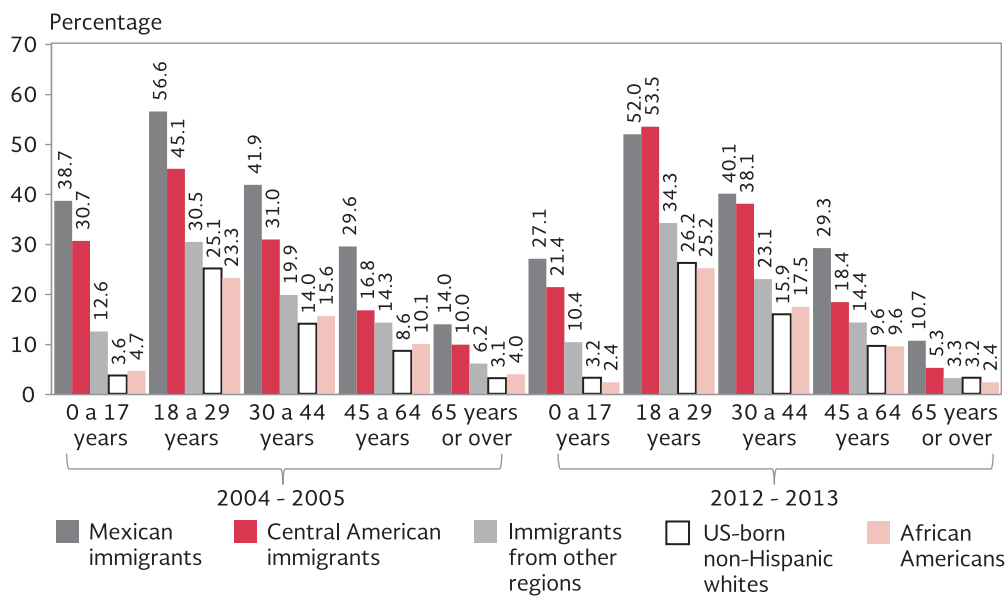
This disadvantage among Mexican immigrants is reproduced across all age groups, though it is higher among those ages 18 to 29, followed by those ages 30 to 44 (Figure 22). The implications of not having a regular source of care have different levels of severity based on the stage of the life-cycle. Childhood and adolescence require continuous and comprehensive medical supervision to encourage healthy physical and intellectual development. Though there has been a significant drop in the proportion of Mexican children and adolescents without a usual source of care, the figure for 2012-2013 remains alarming (27%) in comparison with that of immigrant children from other regions (10%), non-Hispanic US-born whites (3%) and African Americans (2%).

During the later stages of life, health can deteriorate rapidly and chronic illnesses are more likely to develop. As a result, problems associated with the lack of continuous health care multiply. Despite the decreasing disparity between Mexican adults and those in other groups, the percentage of people without a usual source of health care among the oldest group remains relatively high (11%, compared with 3% for immigrants from other regions and non-Hispanic US-born whites, and 2% of African Americans).

It is generally more common for men than women to lack a usual source of care. However, differences between genders are more pronounced among Mexican immigrants (almost 20 percentage points in 2012-2013), followed by Central Americans. At the other extreme are non-Hispanic US-born whites, whose gender gap is under five percentage points.

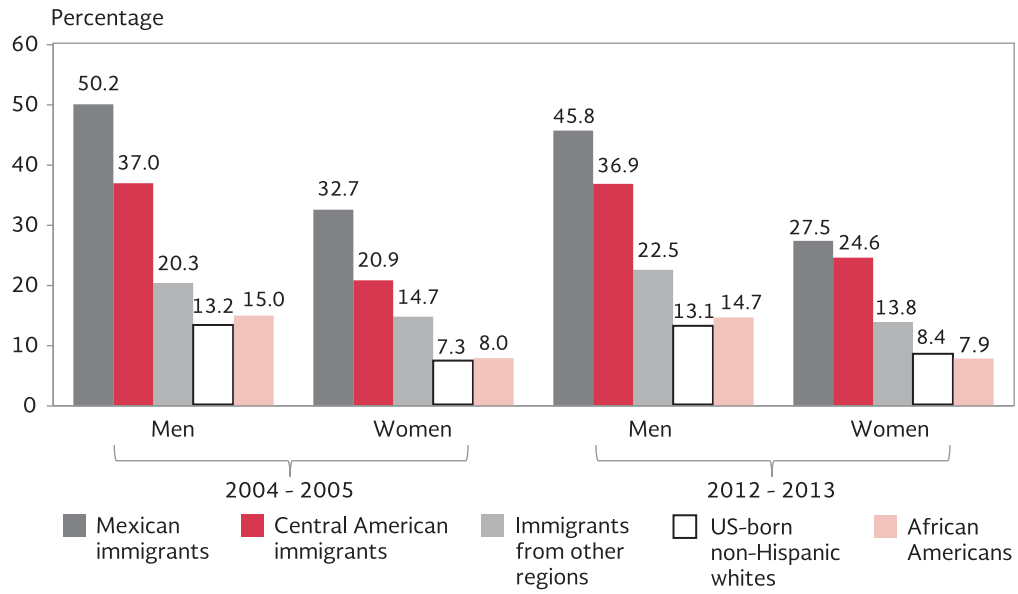
The number of both Mexican men and women without a usual source of health care has decreased during the last decade, although this drop has been more significant among women. This was reflected in a corresponding decrease in the disadvantage *vis-à-vis* women from other population groups (Figure 23).

Figure 22. Population of United States without a usual source of care, by region of origin and ethnicity or race, based on age group, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 23. Population of United States without a usual source of care, by region of origin and ethnicity or race, based on gender, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Type of health care service used

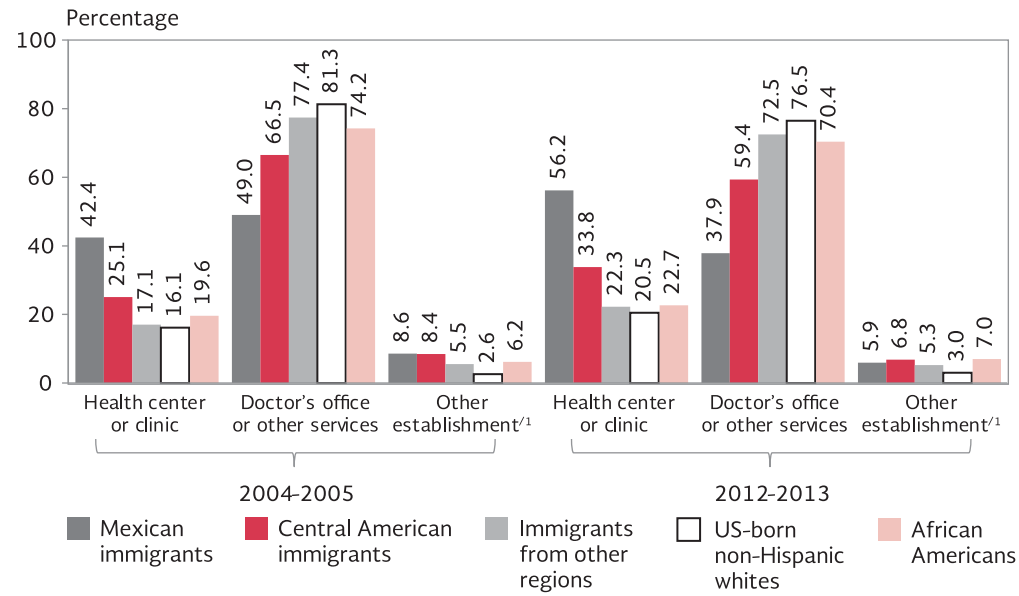
Mexicans use public health centers and clinics more often

The United States offers a wide variety of health care services, including private practices, community clinics and other health centers. Nevertheless, the type of service used is linked to the user's socio-economic level, which varies according to place of origin, ethnicity or race. People treated by private physicians have a greater likelihood of receiving more specialized and personalized care, while those using community health centers or clinics generally receive preventative and primary care services that are less individualized due to a larger number of patients per doctor.

Mexican immigrants that do have a regular place for health care tend to use health centers or clinics, a trend that has recently increased to 56%. This figure is higher than that of Central Americans (34%) and over twice that of immigrants from other regions (22%) and non-Hispanic US-born whites (21%) (Figure 24).

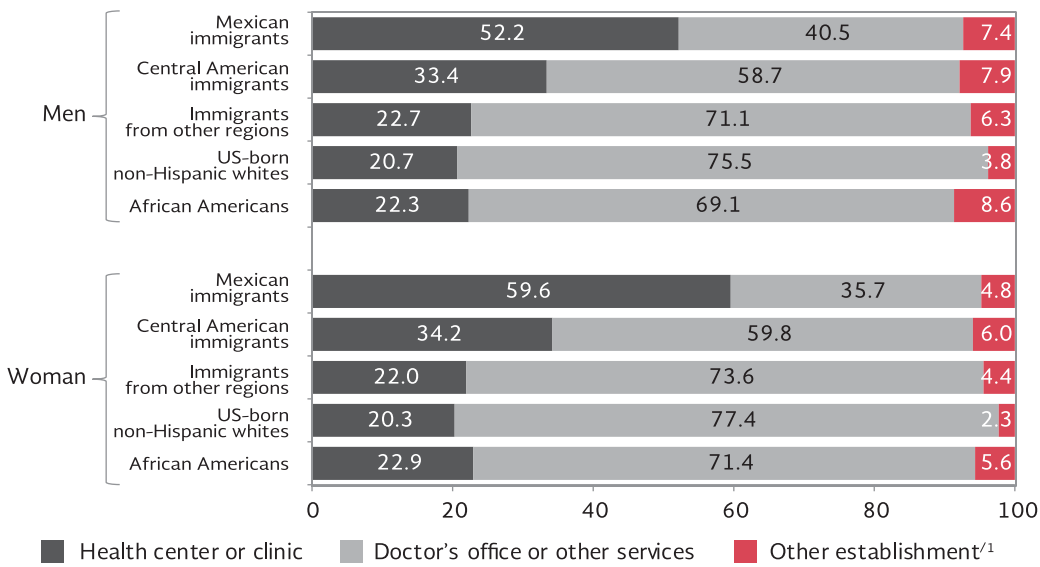
An analysis of data by gender shows that Mexican women use community health centers and clinics more than men (60% and 52%, respectively) (Figure 25). This may be the result of uninsured women seeking prenatal and reproductive health care at community clinics where they can receive services at low or no cost.

Figure 24. Distribution of population of the United States by type of usual source of care, by region and ethnicity or race, 2004-2005 and 2012-2013



Note: 1/ Other establishment: includes emergency department, outpatient department of a hospital and other establishments.
Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 25. Distribution of population of the United States by type of usual source of care, by gender and region of origin, ethnicity or race, 2012-2013

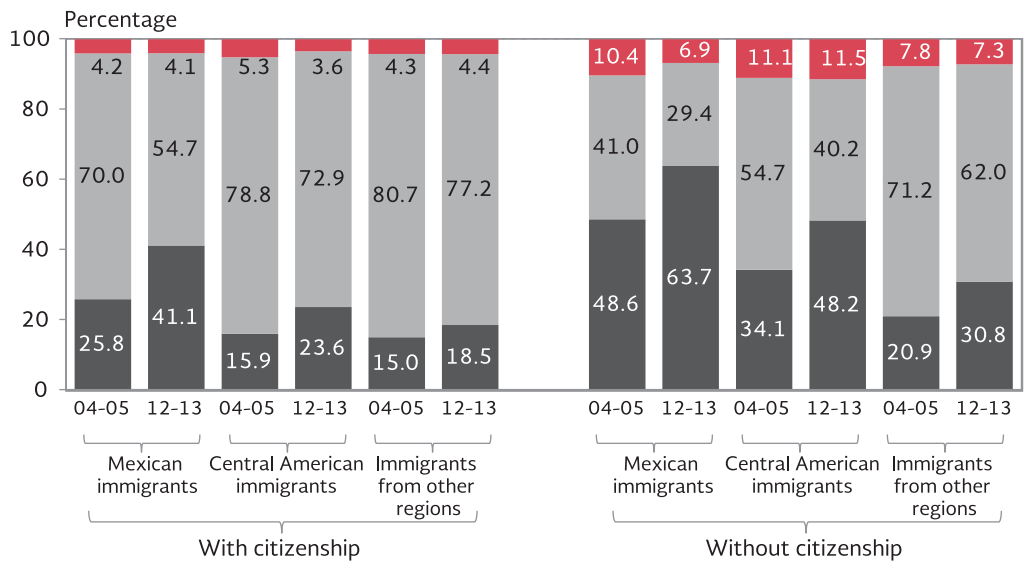


Note: 1/ Other establishment: includes emergency department, outpatient department of a hospital and other establishments.
Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Mexican immigrants without American citizenship use private medical services less

Immigrants without American citizenship are more likely to receive health care at public health care centers or clinics, while naturalized immigrants are more likely to receive care at private practices. This trend has increased over time and is more frequent among Mexican immigrants. Over six out of ten Mexicans without citizenship use clinic services, while 48% of Central American immigrants and 31% of immigrants from other regions do so. On the other hand, almost two out of three naturalized Mexicans use private practices as their usual source of care, though they have recently shown a growing tendency to use health center or clinic services (41%) (Figure 26).

Figure 26. Distribution of immigrant population of the United States by type of usual source of care, by region of origin and American citizenship status, 2012-2013



Note: 1/ Other establishment: includes emergency department, outpatient department of a hospital and other establishments.
Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

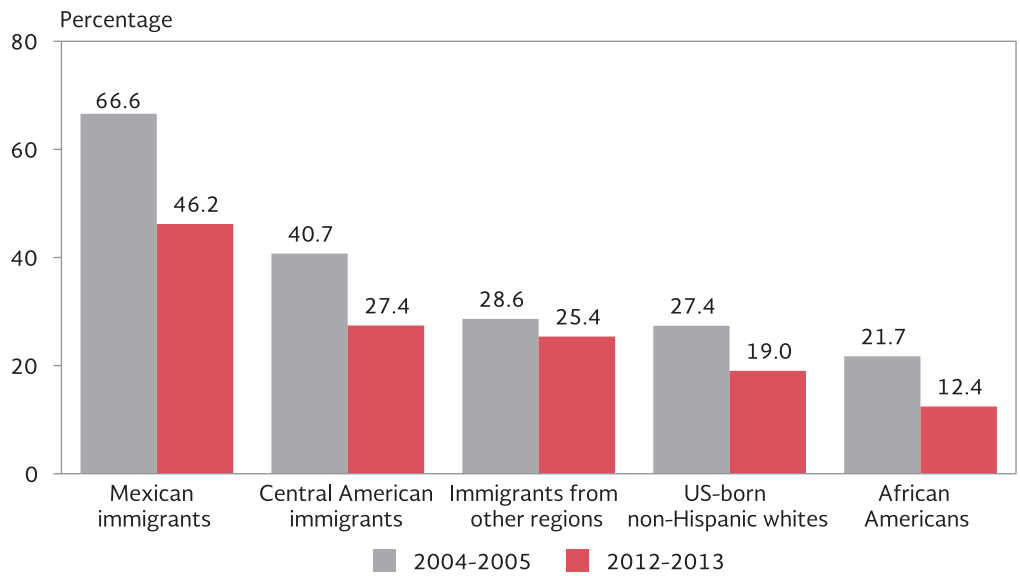
Health Care

Mexican children and adolescents are less likely to meet minimum health standards

Regular visits to the doctor is an important indicator of children's and adolescents' access to health care. The American Academy of Pediatrics highlights the importance of regular health care and recommends that children over two years of age visit the doctor at least once a year until middle childhood (10 years of age) and adolescence (until 21 years of age) to avoid health problems (AAP, 2014).[2] Those who have doctor visits this frequently are more likely to receive regular preventive measures, with favorable consequences for their physical and intellectual development and lifelong health. The available data show that Mexican children and adolescents living in the United States are by far the population group that visited the doctor least frequently in the previous 12 months, though this figure has improved over time. Currently, almost one in two does not meet the minimum standard for medical check-ups, in comparison with approximately one in four immigrants from other regions, one in five of non-Hispanic US-born whites and a just over one in ten African Americans (Figure 27). Mexican-born immigrants are thus the most exposed to the risk of not preventing or obtaining early treatment of ailments or illnesses, which can jeopardize their future development and health.

An analysis of this data by gender reveals that boys are generally less likely than girls to see a doctor as regularly as recommended. It also confirms the disadvantage and greater vulnerability of Mexican chil-

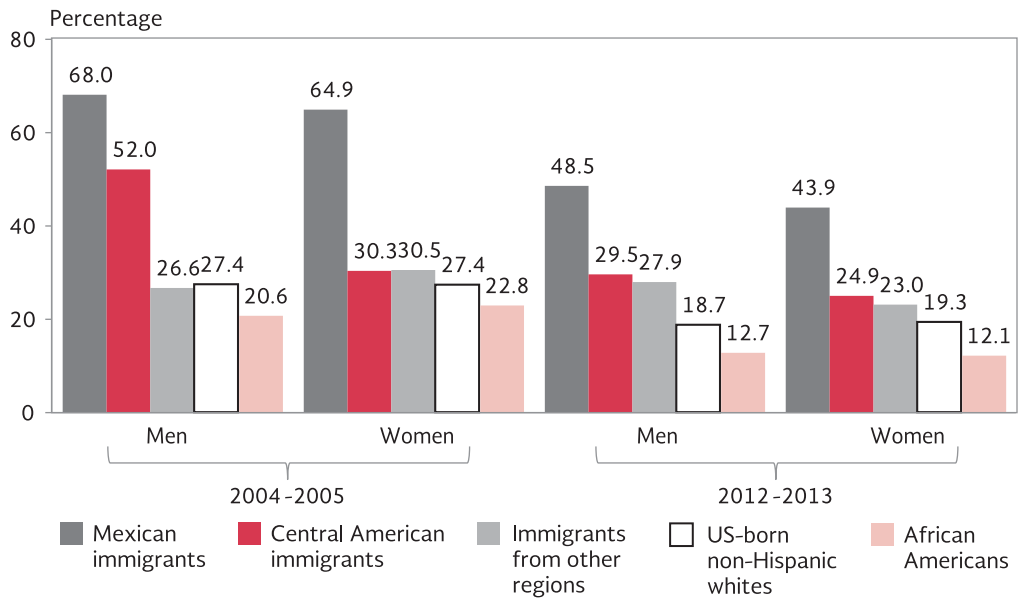
Figure 27. Population between 1 and 17 years in the United States that did not have a medical check-up in the previous 12 months, by region or origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

[2] The Academy recommends more frequent visits (as much as 12 before 3 years of age) during infancy and early childhood.

Figure 28. Population between 1 and 17 years in the United States that did not have a medical check-up in the previous 12 months, by gender, based on region or origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

dren and adolescents across both genders in comparison with their peers from other groups, though the gap has narrowed slightly (Figure 28). The most recent data show that 44% of Mexican girls and adolescents did not visit the doctor in the previous 12 months, a rate approximately 15 percentage points higher than their counterparts from Central America and other regions, twice that of non-Hispanic US-born whites and over three times that of African Americans.

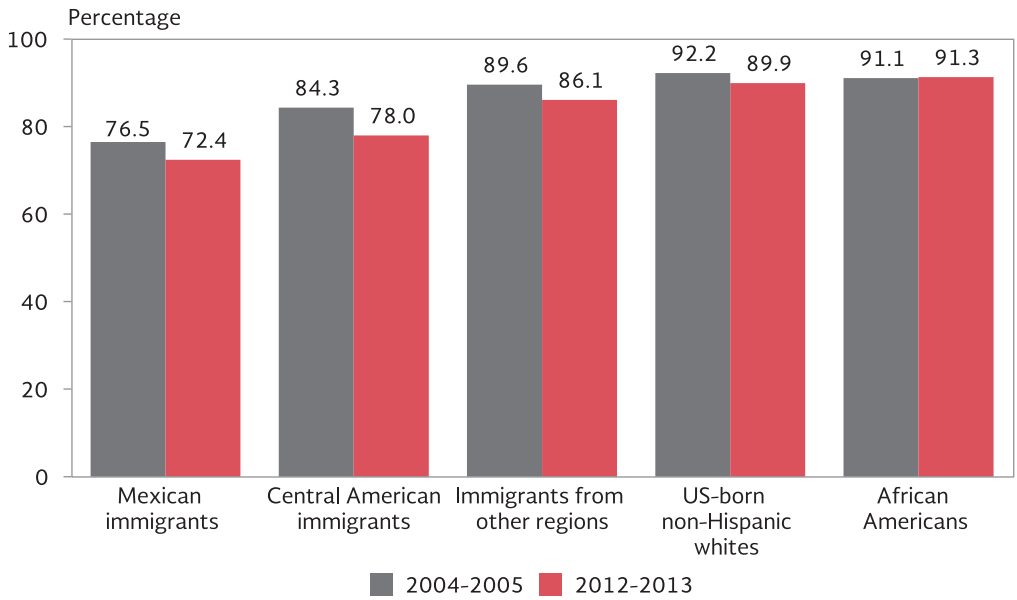
Only seven out of ten Mexican adults who report their health as poor visit the doctor

The regularity with which the adult population uses medical services is closely linked to their perception of their health status. Visits to the doctor are more frequent when health problems are detected, while they tend to be more sporadic when the person perceives their health as good. In addition, economic, cultural and institutional factors influence the regularity of visits to the doctor.

In general, the vast majority of United States residents ages 18 to 64 perceive themselves as being in excellent, very good, or good health (over eight out of ten), and there are no significant differences across the various population groups. However, data show that Mexicans who perceive their health as fair or poor are less likely to visit the doctor in the past year (72%) than other immigrant groups and, above all, less than non-Hispanic US-born whites and African Americans (90% and 91%, respectively) (Figure 29).

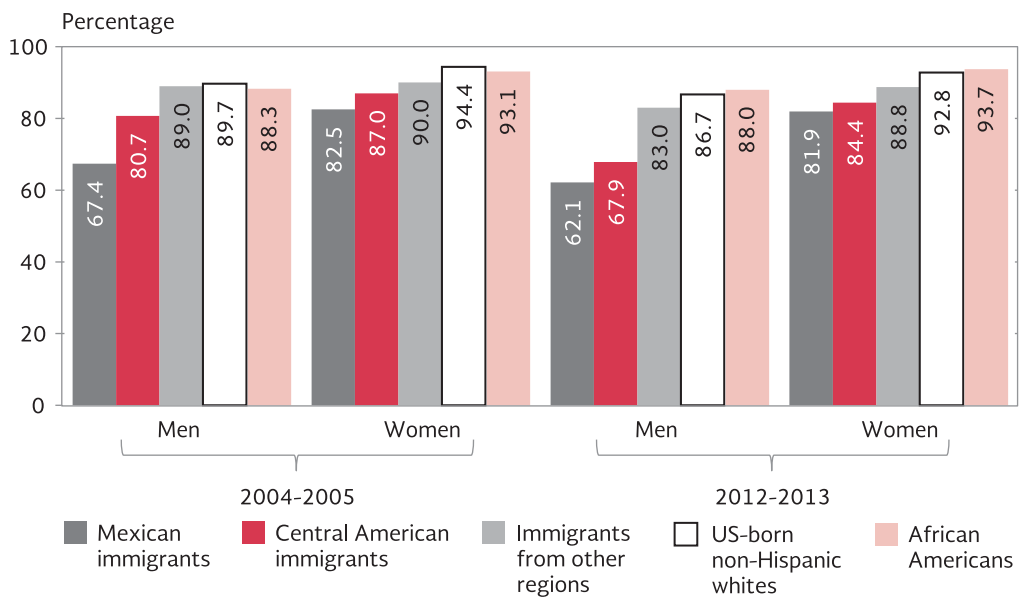
An analysis of doctor visits by gender shows that women across all the groups in this situation were more likely than men to visit a doctor in the previous 12 months (Figure 30). In the case of Mexicans, the difference between men and women is almost 20 percentage points and has grown with time. This indicates the importance of raising awareness among men regarding the danger of not receiving timely health care.

Figure 29. Population between 18 and 64 years in the United States that reports their health as fair or poor and visited a doctor in the previous 12 months, by region or origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 30. Population between 18 and 64 years in the United States that reports their health as fair or poor and visited a doctor in the previous 12 months, by gender, and region of origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, National Health Interview Survey (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Mexican immigrants visit a doctor less frequently than other groups

Mexican immigrant adults also have the longest time since their last doctor visit. Approximately one in four had not had a doctor visit in the past two years and around 15% had done so within the past one to two years. These figures are higher than those for immigrants from other regions and non-Hispanic whites and African Americans. On the other hand, Mexicans, followed by Central Americans, are the most likely to report that they have never visited a doctor (5% in 2012-2013) (Figure 31).

The lower use of health care services by Mexican immigrants and, to a lesser degree, Central Americans, is shaped by the family's socioeconomic context, health insurance coverage, cultural factors, degree of knowledge of the United States health care system, English proficiency and immigration status. Other factors, such as waiting times and the difficulty of obtaining an appointment account for Mexican and Central American immigrants' tendency to delay visiting the doctor (Figure 32).

Routine visits to the doctor and medical tests to check a person's health permit the timely detection of ailments and illnesses.

Figure 31. Distribution of the population between 18 and 64 years in the United States, by date of time since last doctor's appointment, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013

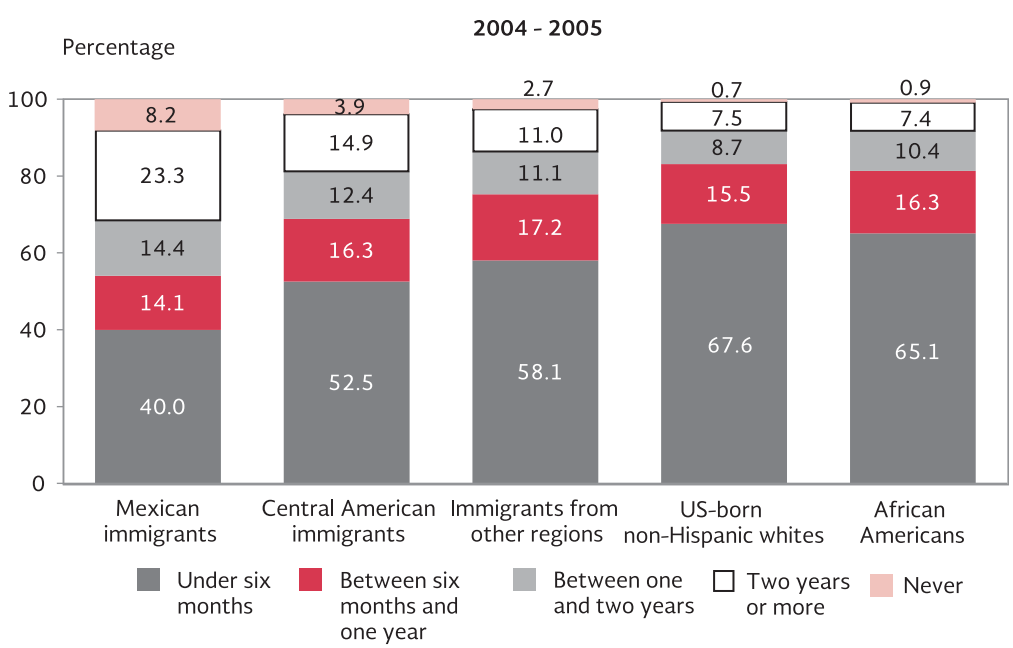


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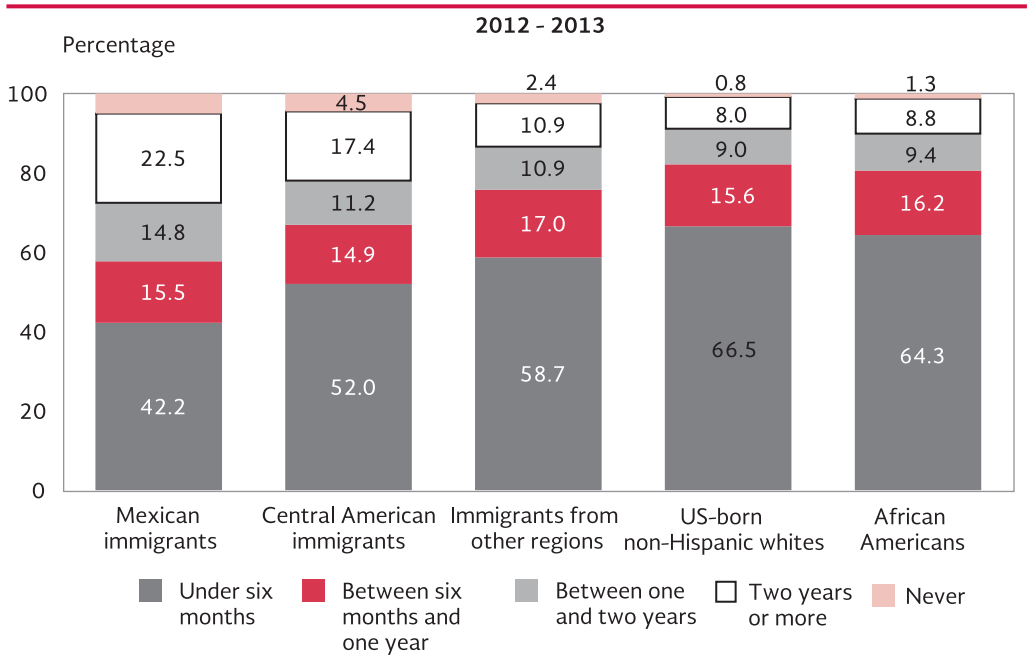
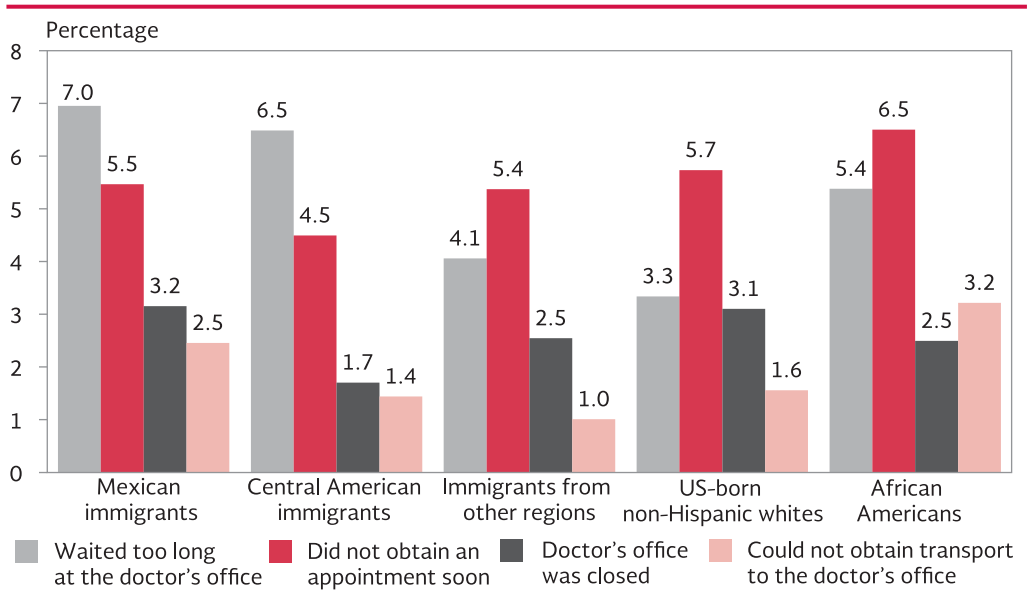
Figure 31. Distribution of the population between 18 and 64 years in the United States, by date of time since last doctor's appointment, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2004-2005 and 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 32. Population between 18 and 64 years in the United States by reason for delay in receiving health care in the previous 12 months, by region or origin and ethnicity or race, 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

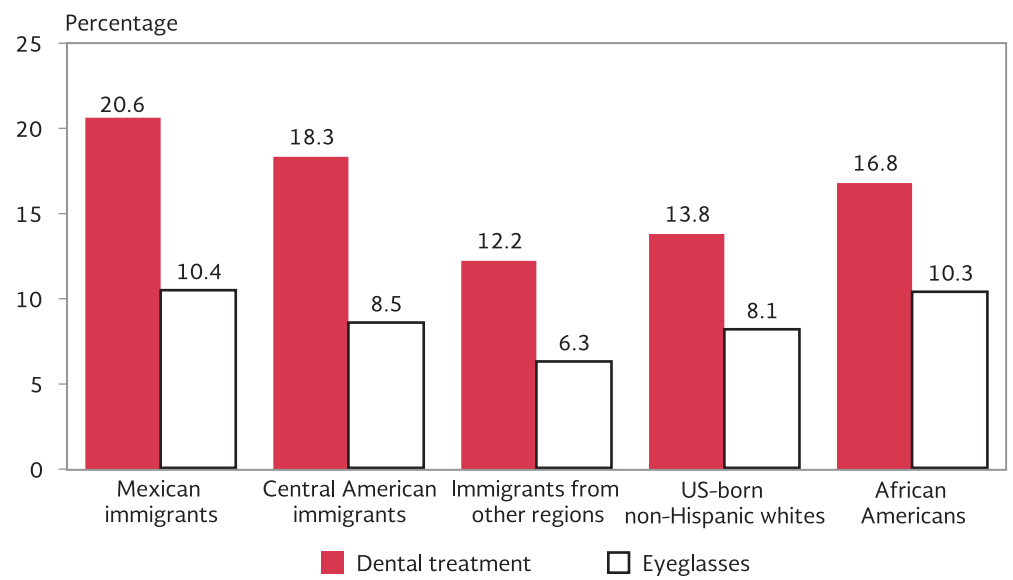
The available data show that one in five Mexican adults did not receive dental care, even when it was necessary, a higher figure than among other population groups. Moreover, like their African American counterparts, one in ten reported that they need eyeglasses but did not obtain them (Figure 33).

Diabetes is an illness that significantly affects the Mexican population, both in Mexico and the United States, and needs to be prevented and controlled over a person's lifetime. However, both Mexican and Central American immigrants are less likely than those from other regions and non-Hispanic US-born whites and African Americans to have glucose tests in the past year (just over one in three, compared with four out of ten respectively) (Figure 34). Men are less likely than women to have this test across all of the groups. However, the gender gap among Mexican and Central American immigrants is very pronounced, since very few men in these two groups get tested (27% and 28%, respectively).

Mexican immigrants are the group that has an Human Immunodeficiency Virus (HIV) test least frequently, with under 40% of 21 to 50 year-olds doing so, while approximately half of Central Americans and two out of three African Americans have done so. In all of the groups, the proportion of women having undergone an HIV test is higher than that of men. Nonetheless the gender gap among Mexicans (17 percentage points) is far above that of other immigrant groups and the US-born population (Figure 35). These low rates of screening, especially for Mexican immigrant men, are a concern since routine HIV testing is recommended by the Center for Disease Control and Prevention (CDC, 2006).

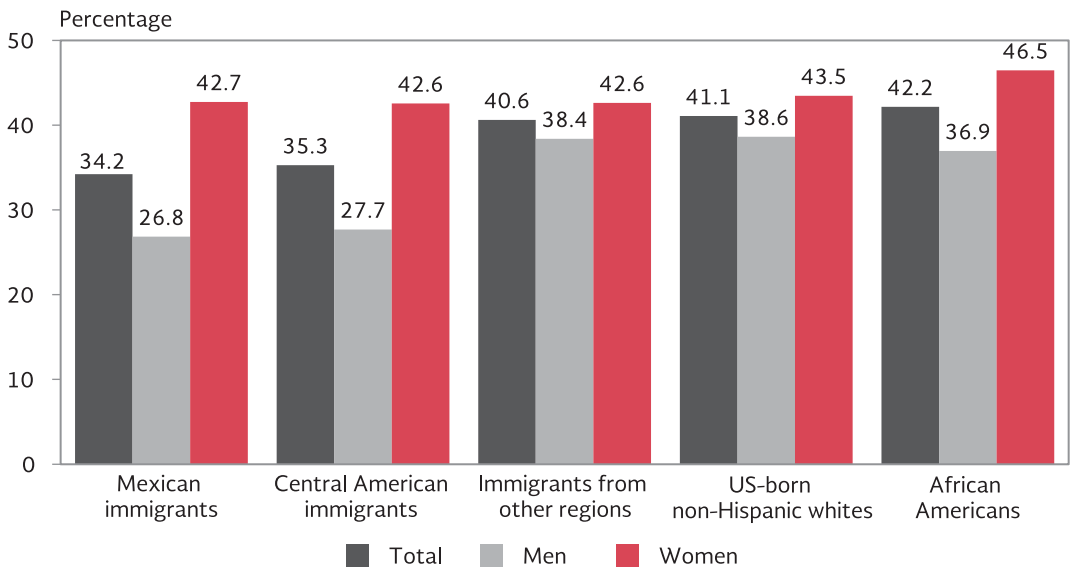
Only 22% of Mexican immigrants and 32% of Central Americans were aware of the Human Papilloma Virus Vaccine (HPV), which was recently incorporated into the set of sexual and reproductive health services recommended for adolescents and adults. This rate was significantly lower than among

Figure 33. Population between 18 and 64 years in the United States that required dental treatment or eyeglasses in the past 12 months and did not obtain it, by region or origin and ethnicity or race, 2012-2013



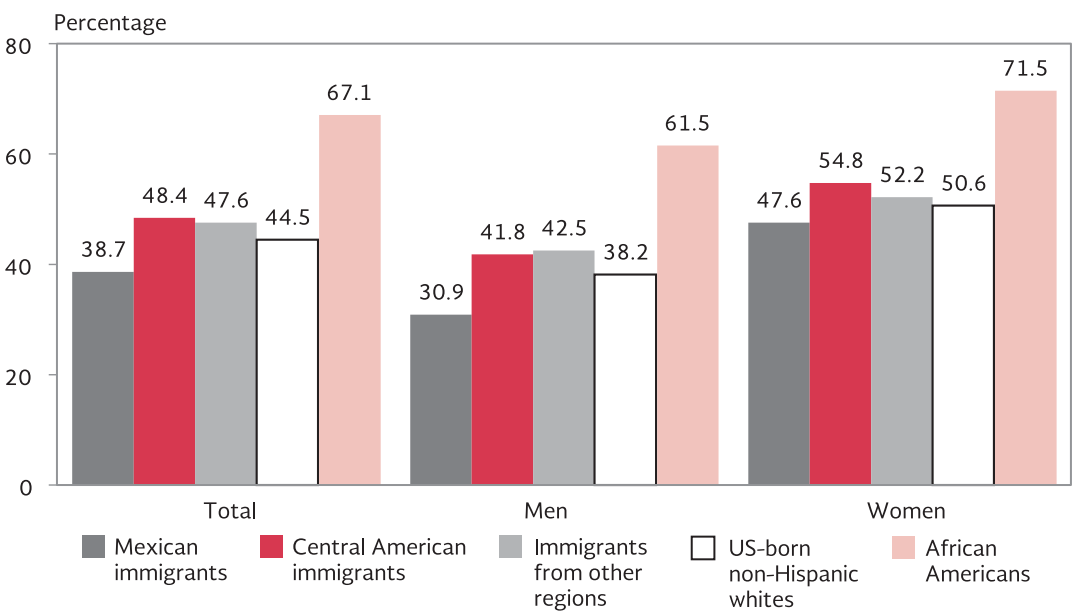
Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 34. Population between 18 and 64 years of the United States that had a glucose test in the previous 12 months, by gender, based on region of origin and ethnicity or race, 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 35. Population between 21 and 50 years of the United States tested for HIV, by gender, based on region of origin and ethnicity or race, 2012-2013



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

other immigrants and natives (Figure 36). Knowledge of this innovation in cervical cancer prevention also shows a gender gap in all the groups analyzed, to with men having the lowest knowledge.

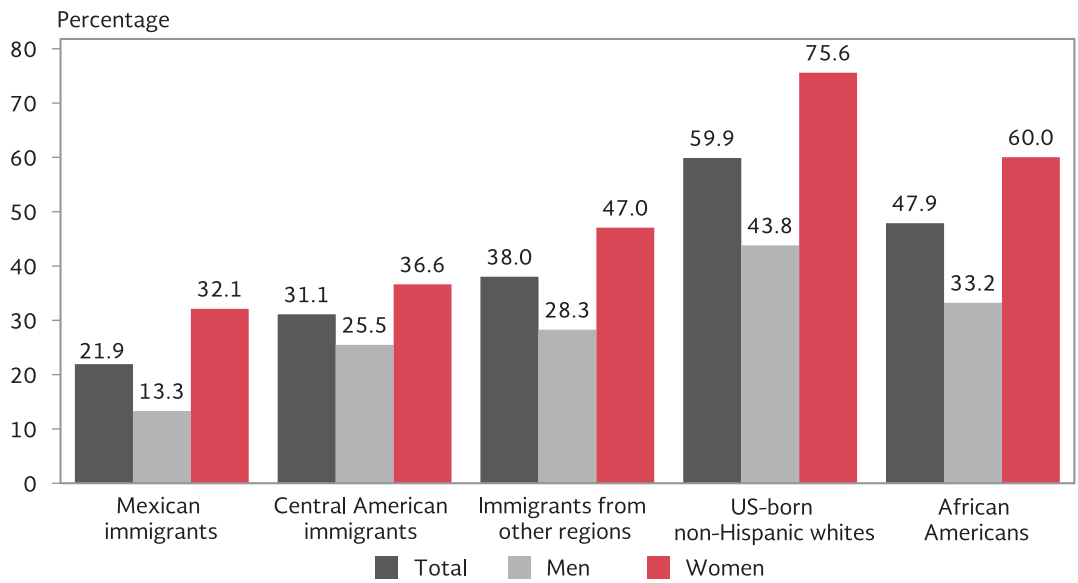
The information also indicates that tests designed to provide for the early detection and treatment of cancers are less frequent among the Hispanic population (both US-born and immigrant) in the United States, in comparison with non-Hispanic US-born whites and African Americans (Figure 37).

Health coverage and medical service use among Mexican immigrants in the United States is noticeably lower than among other groups in the country. The population of Central American origin has also seen a decrease in the level of health insurance coverage in recent years.

Unequal access also affects men disproportionately and is present across all age groups. Children and older adults are particularly affected by exclusion from the health care system. Though this inequality can be observed in every state in the country, some including several that receive numerous Mexican migrants provide immigrants and their families distinctly unfavorable conditions for social integration and medical care.

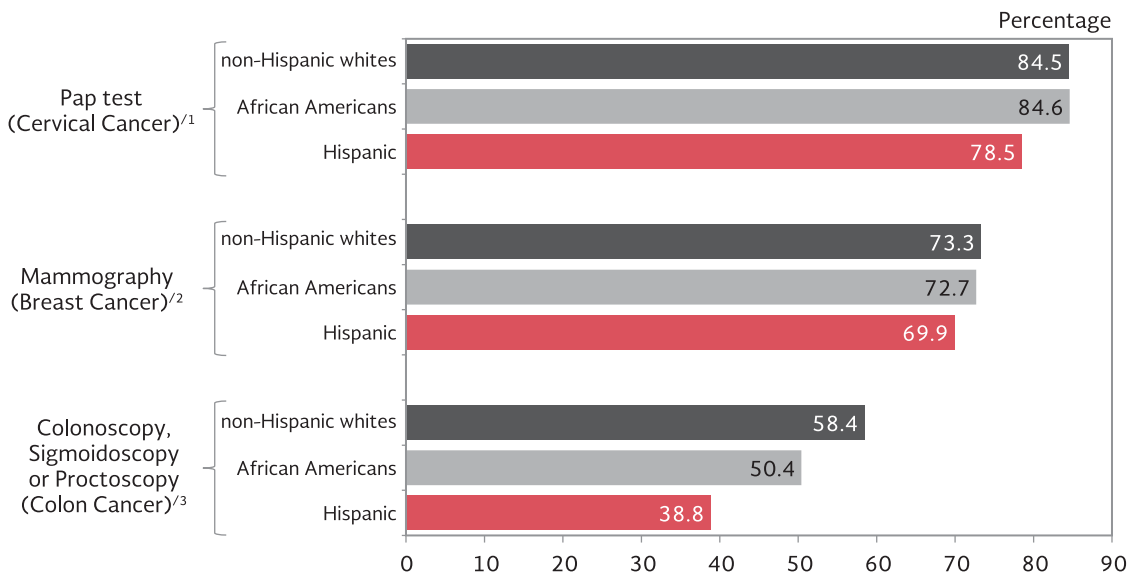
Overall, factors such as Mexicans' concentration in certain sectors of the economy also condition a framework of salary and benefits, which has contributed significantly to reproducing the economic and social deprivation of this group in the United States. The result is worse access to needed health services for Mexican immigrants, and often for Central American immigrants, than for all other groups. Mexican immigrants are the group least likely to see a doctor, obtain needed dental care and eyeglasses, and receive clinical preventive services that can identify health problems early so that they can be more effectively treated.

Figure 36. Population between 18 and 64 years in the United States that has heard of the vaccination against the Human Papilloma Virus (HPV), by gender, based on region of origin and ethnicity or race, 2012



Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012. Integrated Health Interview Series. Minneapolis: University of Minnesota.

Figure 37. Population living in the United States with timely cancer detection tests, by ethnicity or race



Notes: 1/ Women between 21 and 65 years who had a Pap test in the previous three years.
2/ Women between 50 and 74 years who had a mammography in the previous two years.
3/ Adults over 50 years who once had a colonoscopy, sigmoidoscopy or proctoscopy.

Source: Migration Policy Bureau, SEGOB, based on U.S. Department of Health & Human Services, *National Healthcare Disparities Report*, 2012.

Box I. The Impact of the ACA on Hispanics in 2014

The *Patient Protection and Affordable Care* Act (ACA) was signed into law in 2010 as a reform of the health and medical insurance system for all Americans and lawful permanent residents. The law aims to introduce new protections for consumers, lower costs and improve quality of care, and improve access to affordable care, with implementation from 2010 to 2015. Hispanics are a key target population for these efforts. In 2011, prior to the initial implementation of the ACA, they represented around 17% of the population but 32% of the nation's uninsured.

Hispanic communities and many Mexican immigrants have benefitted from the ACA. They are profiting from expanded eligibility for *Medicaid* (for low-income persons) in half of the states, from subsidized insurance offered through new health benefit exchanges if their incomes are low but above the poverty level, via increased funding of community clinics that provide primary care based on ability to pay, or through increased coverage of preventive services in all health insurance policies. However, certain segments of the Hispanic population, particularly undocumented immigrants and mixed-status families, are still underinsured, with consequent risks to health.

In 2014 some of the most significant provisions of the ACA went into effect, particularly those aimed at reducing the uninsured rate. The most widely discussed is the new federally subsidized private insurance offered through government-organized "marketplaces" in each state. Open enrollment in the Health Insurance Marketplaces began in October, 2013 with an additional special enrollment period that lasted until April, 2014.

Hispanics in the United States are seen a main beneficiary group of the ACA; they were disproportionately underinsured, representing 1 in 4 eligible Health Insurance Marketplace consumers. Because of the ACA, about 10 million Hispanics have new access to health insurance coverage, and 80% of uninsured Hispanics are eligible for assistance through *Medicaid* or a Marketplace (DHHS, 2014).

Despite the great benefit provided by the ACA, Hispanics are among the most likely to remain uninsured, possibly due to cultural and linguistic issues, the presence of mixed-status families and that fact that a disproportionate part of the undocumented population is Hispanic and thus not covered by the law. Mixed-status families are those with members who have different citizenship or immigration statuses. While the legal resident members of the family may be eligible for public programs and subsidies, there is a "chilling effect" that deters enrollment that comes from concerns over being detected by the immigration authorities and (often unjustified) fears that if their US-born children enroll in government subsidized health insurance that the parents may be barred in the future from obtaining a green card. Although the information gathered for enrollment in these programs is not used for immigration enforcement, misunderstandings or fear about this may be a barrier to getting coverage for mixed-status families.

Surveys of first enrollment efforts show growth in health insurance coverage of the population and a decline in the number of young people who are uninsured. From the beginning of open enrollment until the end of the special enrollment period, 8 019 763 people signed up for health coverage under a Health Insurance Marketplace, either state-based or federally managed. Of those, 403 632 reported Hispanic ethnicity, representing 10.7% of enrollments among those who reported an ethnicity. Of all enrollees, 34% (or around 2,700,000)

were young people under 35 years old (DHSS, 2014b). Enrollment surged during the special enrollment period, with over 900 000 new enrollments, many of whom were young people. In addition to the more than 8 million people who signed up for insurance under a Health Insurance Marketplace, numerous others have purchased off-marketplace plans. Estimates of the total decrease in the uninsured population from 18 to 24 years old range from 2.7% to 4.7%.

The ACA also had an important impact on enrollment in the *Medicaid* program. Growth in *Medicaid* enrollment has been strong, with a total of over 65 million persons covered and an estimated 10% growth between the summer of 2013 and April 2014. While only about half of states decided to take the federal funds available to expand their *Medicaid* programs, the publicity and outreach under the ACA was expected to have some impact on *Medicaid* in all states. As would be expected, in the states that expanded *Medicaid* to cover more low-income adults, the growth in enrollment outpaced the national average and was higher than in states that had not (15% vs 3.3%) (HKFF, 2014). In California, enrollment increased by a monthly average of 19% from the pre-open enrollment average until June 2014 (HKFF, 2014b).

Hispanic enrollment rates are also likely to be affected by the many undocumented workers and their families in their ranks. By excluding undocumented residents, the ACA has little impact on rates of health insurance coverage for this vulnerable group that is the most uninsured of any group. This provision implicitly affects Mexicans, above all other groups. It is estimated that Mexicans make up 59% of the undocumented population (Hoefer et al., 2013). Those who are undocumented are restricted from the subsidized programs of the ACA, however, they can take advantage of health system improvements in other ways. For example, there is increased funding available for community health centers, where services are often offered regardless of immigration status, and where 1 in 3 patients is Hispanic. In addition, a greater focus on preventive care and the expansion of free or low-cost preventive treatments will improve management of diseases that are prevalent among Hispanics.

Improving health access for Hispanic and Mexican immigrants in particular requires better understanding and addressing the barriers they face in enrolling for coverage. Special outreach and education efforts may be necessary to target mixed-status families. Removing the ACA's restrictions on the undocumented would help increase Hispanic enrollment in health insurance coverage. Given that most undocumented residents tend to be young and in good health, expanding the ACA to cover all residents, regardless of immigration status, would support both the Health Insurance Marketplaces and the health preservation of these individuals. Any comprehensive immigration reform should include a mechanism for access to affordable health services, either in the United States or in the country of origin (SEGOB, CONAPO, UC, 2013).

Chapter III
Risk factors and health conditions

Introduction

There are many studies that document that immigrants tend to arrive in the US healthier than the US-born population, but that their health generally declines over time. Understanding the pattern of health risk factors and the health conditions that the Mexican immigrant population lives with provides critical insights into where additional efforts need to be made to prevent future illnesses and treat current conditions. This is particularly important for the Mexican immigrant population because of their low levels of access to health care as documented in the previous chapter.

This chapter is divided into two sections, the first of which addresses the habits that can undermine a person's health in the short-, medium- and long-term, and above all those linked to chronic illnesses. Two population groups, children (0 to 17 years) and adults (18 to 64 years), based on region of origin and ethnicity or race are analyzed. The second section shows some of the health conditions that affect children, nonelderly adults and adults age 65 and over.

The principal source of data is the *United States National Health Interview Survey* (NHIS), published by the Centers for Disease Control (CDC), which contains information for two periods, 2004-2005 and 2012-2013. The analysis is complemented with data from the *National Report of Health Disparities 2012*, published by the Agency for Health Research and Quality (AHRQ), which does not provide data for Mexicans but instead aggregates information for the entire Hispanic group (both immigrant and US-born), which is only compared with non-Hispanic US-born whites and African Americans.

Two issues impact the trends presented here. First, as indicated in the previous chapter, Mexican immigrants and Hispanics overall have a lower use of medical care services, which may result in an underreporting of health conditions due to lower chances of being diagnosed. Second, there may be an underreporting of persons given the marginalization and undocumented status of a large number of Mexicans living in the United States.

Risk factors

Children and adolescents

It is important to study the health of children and adolescents in the United States since the risks they face can not only jeopardize their health throughout childhood, but also have consequences in their adult lives. The health conditions of this population group also highlight the need for medical treatment in the US and possibly in Mexico, considering the possible return of these young migrants to their country of origin at later stages of their lives.

Immigrants and African Americans have the highest likelihood of low birth weights in comparison to non-Hispanic US-born whites

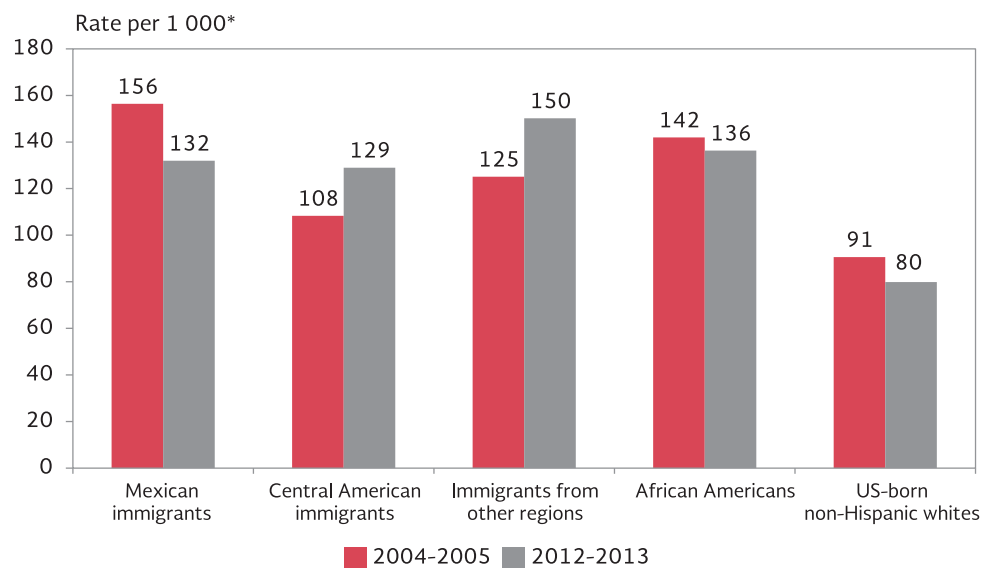
Low birth weight often indicates insufficient or non-existent prenatal care, which can detect and monitor the nutritional state of the mother and identify risks for her health and that of her child. Low birth weight is one of the most important causes of neonatal mortality, and has negative repercussions on child development.

Low-weight births among Mexicans decreased over the past decade, from 156 per thousand in the first period (2004-2005) to 132 in the second (2012-2013). While this is the only immigrant group that recorded a decrease, the disparity in comparison to non-Hispanic US-born whites is still 52 cases per thousand. On the other hand, there is a worrying increase of 21 cases per thousand among Central Americans, though this is still slightly below the rate for Mexicans and African Americans (Figure 38).

Mexican immigrant adolescents have the highest weight in relation to their height

Although adolescence tends to be a healthy stage of life, a number of 12 to 17-year-olds die of preventable causes, including accidents, suicides and violence. Moreover, it is a stage during which future behavioral patterns are established, such as alcohol and cigarette consumption as well as habits relating to diet and physical activity, all practices that can contribute to premature illnesses later in life that can undermine quality of life and lead to premature death (ss, 2012). Reaching a high body weight at an early age makes it difficult to maintain an optimal weight at a later age, which can cause a series of complications such as metabolic syndrome, high blood pressure, glucose intolerance due to insulin resistance, obesity and cardiovascular illnesses, among others.

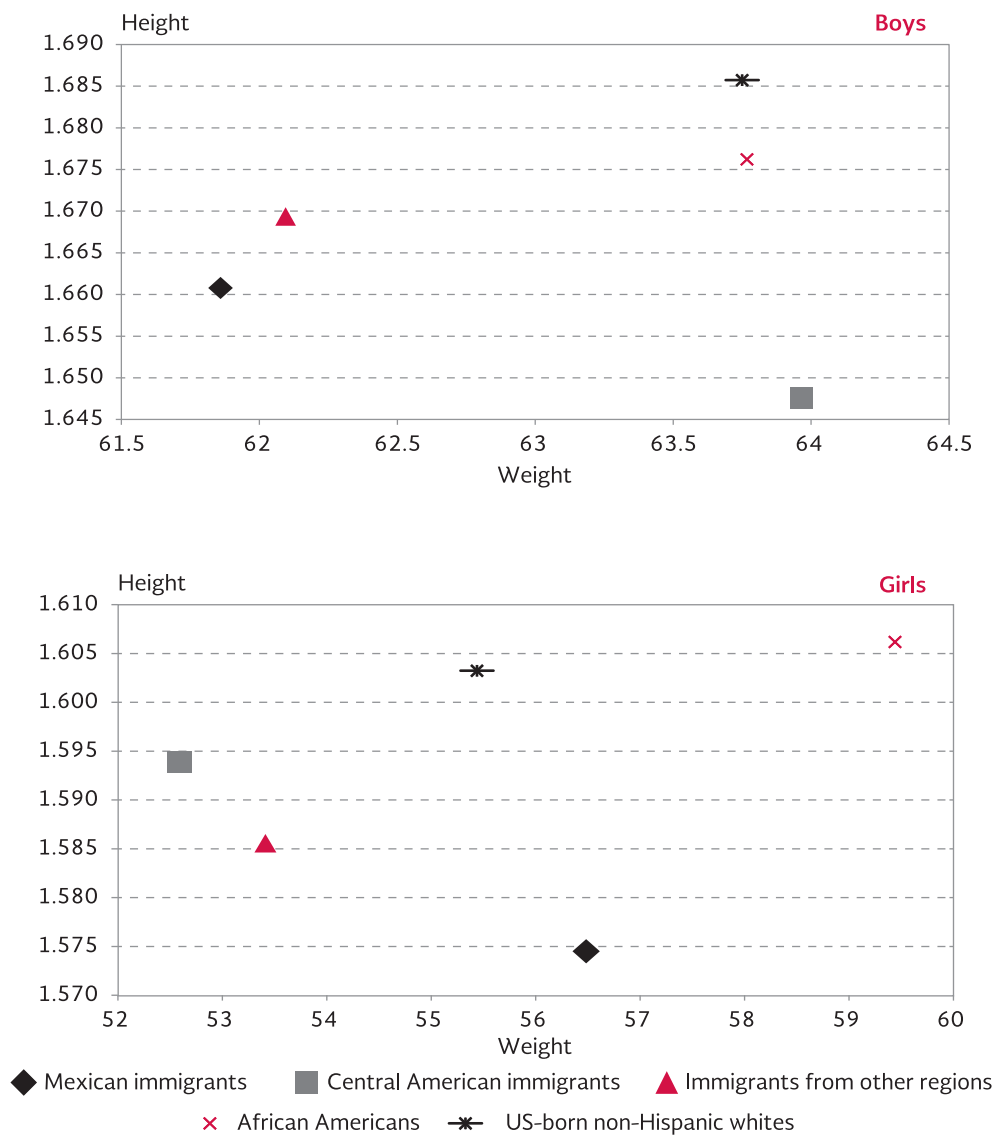
Figure 38. Population living in the United States with low birth weight, by region of origin and ethnicity or race, 2004-2005 and 2012-2013



Note: * For every 1 000 children under 18 years with low weight birth.
Source: Estimates by CONAPO, based on *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Adolescents living in the United States are widely exposed to foods with high levels of fat, salt and sugar which, combined with physical inactivity, increase the prevalence of overweight and obesity. Among the groups studied, Mexicans between 12 and 17 years display the highest average weight in relation to average height for females, while Central Americans have the highest weight and lowest height for males (Figure 39).

Figure 39. Population ages 12 to 17 living in United States, by average height and weight, based on region of origin and ethnicity or race, 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Adults

In addition to the behavior acquired at an earlier age, a series of risk factors in adulthood, such as obesity, physical inactivity and alcohol and cigarette consumption, contribute to the development of chronic illnesses including diabetes, cardiovascular diseases, chronic respiratory diseases, hypertension and certain types of cancer (SS, 2012b).

Approximately eight out of ten Mexican men and seven out of ten Mexican women are overweight or obese

Obesity is a leading modifiable risk factor. The Body Mass Index (BMI) is the most often used measure for identifying this condition. Mexican men and women have the highest increase in BMI as measured by overweight, obesity and morbid obesity. Indeed, 71.3% of Mexican men were in these three categories in 2004-2005, rising to 78.7% in 2012-2013. The percentage of Mexican women in these categories increased from 65.5% to 72.2%. As a result, in 2012-2013 Mexican men were the group with the highest rates of overweight and obesity, while Mexican women had a rate lower only than that of African Americans (Figure 40).

Migrants incorporate new foods from the country of destination into their diets, but Mexicans do not usually undergo a drastic change in diet after migration. Yet some studies have shown that, although they continue to consume typical foods from their national cuisine, they also incorporate new foods that are high in concentrated sugar and saturated fats (Arenas *et al.*, 2013; Popkin, 2006).

The percentage of the Mexican population who are overweight and obese is higher among long-term residents (77%) than recent arrivals (68%). This reflects the migrants' diet in the receiving country, conditions of socioeconomic integration and higher average age of longer-resident migrants. Recent Mexican arrivals display higher rates of overweight and obesity than a decade ago (seven out of ten, previously six out of ten), which can partly be explained by the higher average weight in the country of origin (Figure 41).

Figure 40. Population over age 18 living in the United States, by BMI Category*, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013

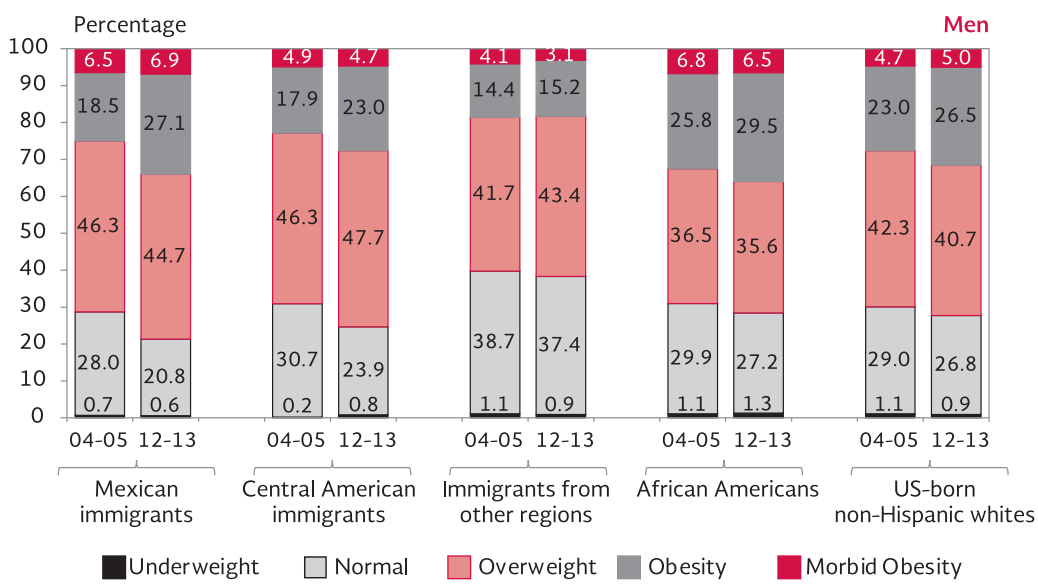


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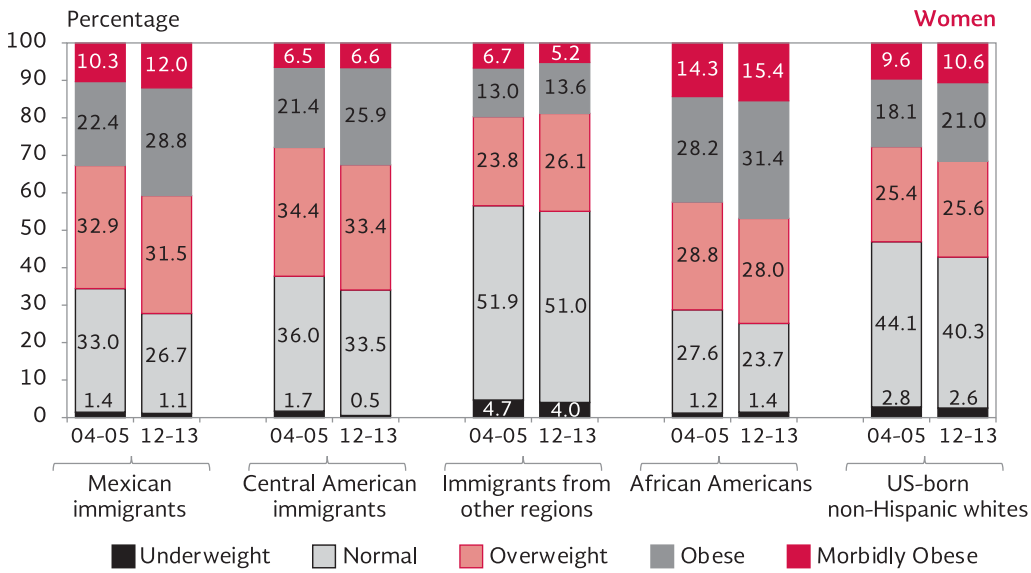
Figure 40. Population over age 18 living in the United States, by BMI Category*, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013



Note: *Underweight: BMI<18.5; Normal: BMI >=18.5 and <25.0; Overweight: BMI >=25.0 and <30.0; Obese: BMI >=30 and <40.0: Morbidly Obese: BMI >=40.0.
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Mexican adults remain the group with the highest rate of physical inactivity

Physical activity can reduce the risk of many illnesses and improve the outcomes of some of those conditions. Changes in technology and working conditions have fostered more sedentary lifestyles, with brief periods of physical activity. Physical inactivity is thus the fourth highest risk factor of mortality worldwide (ss, 2012c).[1]

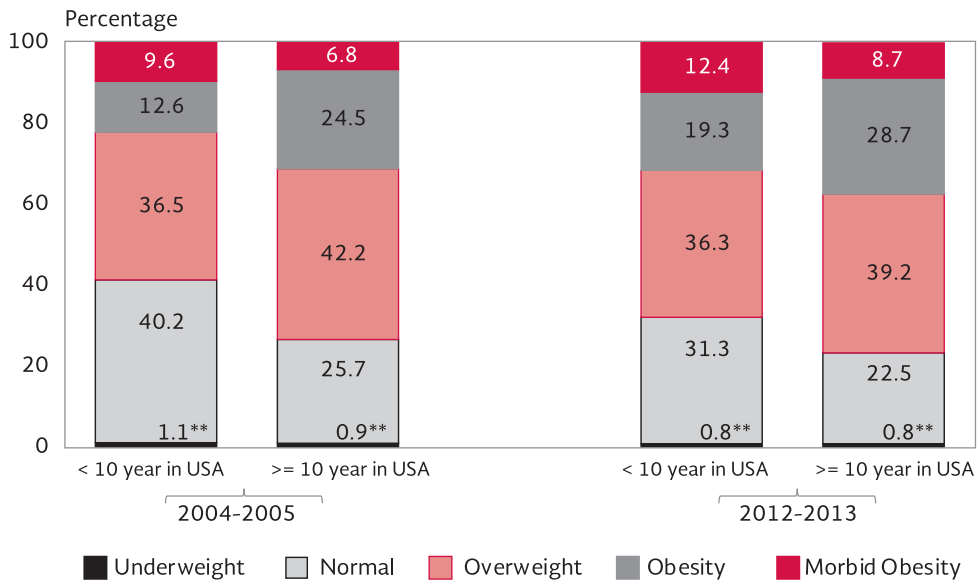
Though the percentage of persons engaging in physical activity increased between the two periods, Mexicans had the highest levels of inactivity during the period 2012-2013 (39.7%) (Figure 42). However, Mexicans saw the most significant decrease in sedentary lifestyle (16.4%), over twice that recorded among non-Hispanic US-born whites (7%). A comparison of the percentage of Mexican population and the US-born population without physical activity by gender follows the same pattern. For example, during 2012-2013, 39% of Mexican men and 40% of Mexican women did not engage in regular physical activity, while non-Hispanic US-born whites reported percentages of 24% and 28%, respectively (Figure 43). Importantly, Mexicans have an extremely low tendency to engage physical activity, which, as will be examined later, is reflected in higher levels of obesity and diabetes for both genders.

Alcohol abuse and tobacco are important preventible causes of illness and death

Alcohol and cigarette abuse are risk factors that can also be modified. These habits are linked to each other and other chronic diseases. Excessive alcohol use is a direct cause of risk behavior, accidents and severe hepatic diseases such as cirrhosis (Guerrero *et al*., 2013). Cigarette use is a risk factor responsible for cardiovascular illnesses, diseases of the oral cavity, saliva glands and jaw, buildup around the teeth

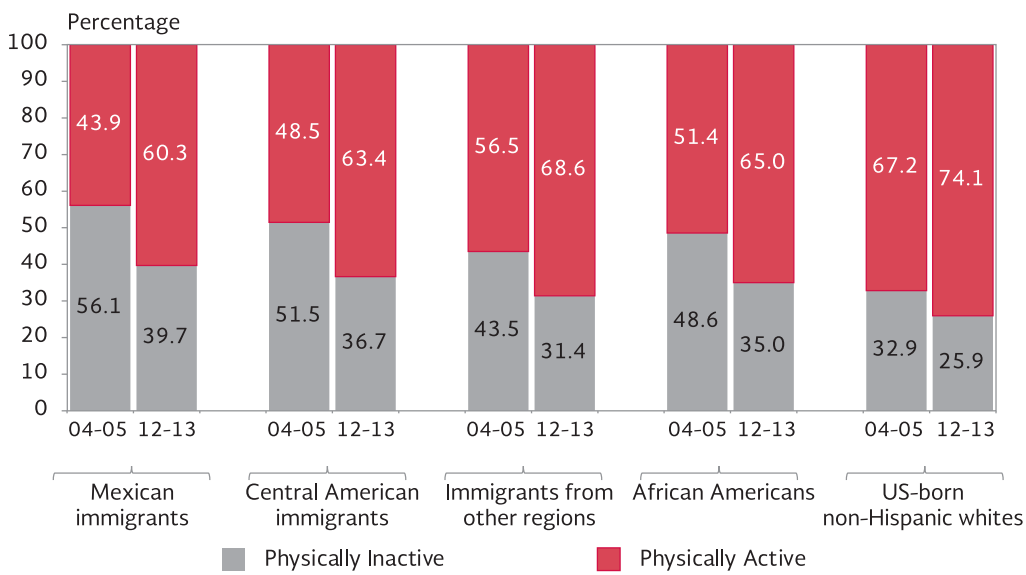
[1] Here the definition of engaging in physical activity is taking part at least once a week in moderate, vigorous or heavy activities.

Figure 41. Mexicans living in the United States, by BMI Category*, based on length and year of residency, 2004-2005 and 2012-2013



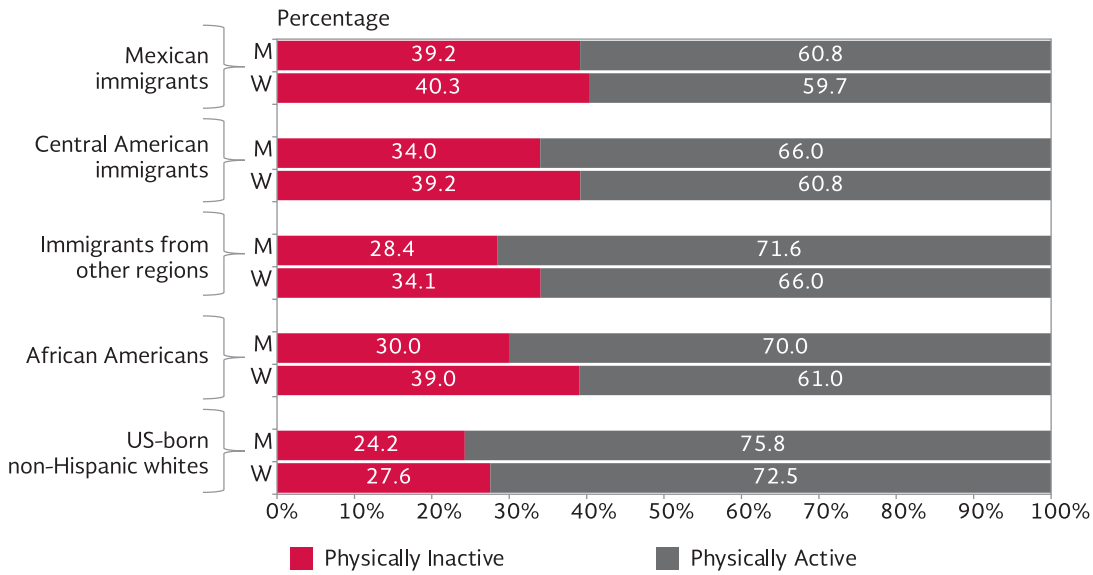
Notes: *Underweight: BMI<18.5; Normal: BMI >=18.5 and <25.0; Overweight: BMI >=25.0 and <30.0; Obese: BMI >=30 and <40.0: Morbidly Obese: BMI >=40.0.
** Non-representative information.
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 42. Population ages 18 to 64 living in the United States, by physical condition, based on region of origin and ethnicity and race, by period, 2004-2005 and 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 43. Population ages 18 to 64 living in the United States, by level of physical activity and gender, based on region of origin and ethnicity or race, 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2012-2013.

and complications in the respiratory system, chronic obstructive pulmonary disease (COPD) and malignant trachea, bronchus and lung tumors. Moreover, in women it is associated with complications during pregnancy and childbirth (Fiore *et al*., 2001).

Alcohol use has increased among Mexicans in recent years

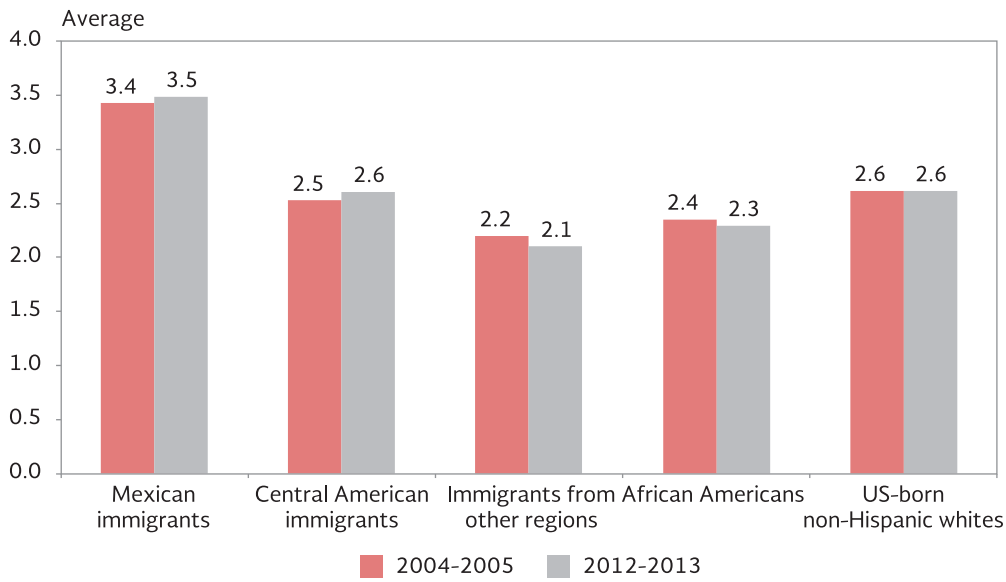
On average Mexicans who drink consume more alcohol than other groups per occasion (3.5 drinks at a time). Only they and Central Americans (whose average consumption of 2.6 drinks is equal to that of non-Hispanic US-born whites) recorded a slight increase between 2004-2005 and 2012-2013 (Figure 44).

Among both Mexican immigrants and non-Hispanic US-born whites, the amount of alcohol consumed on each occasion decreased with age, and consequently in 2012-2013, while young Mexicans between 18 and 29 years had a little over four drinks every time they consumed alcohol, adults between 45 and 64 years had one drink less. A similar pattern emerged among non-Hispanic whites in these age groups (Figure 45). In addition, the average number of drinks by younger Mexican immigrants ages 18-29 years increased over the past 10 years to just over four drinks at a time, while the average of drinks in the same age group of US-born non-Hispanic whites decreased. Since binge drinking is defined as five or more drinks on a single occasion for men, and four drinks for women, this data suggests high levels of dangerous binge drinking among the Mexican immigrant population that drinks alcohol.

Mexicans smoke fewer cigarettes than other groups

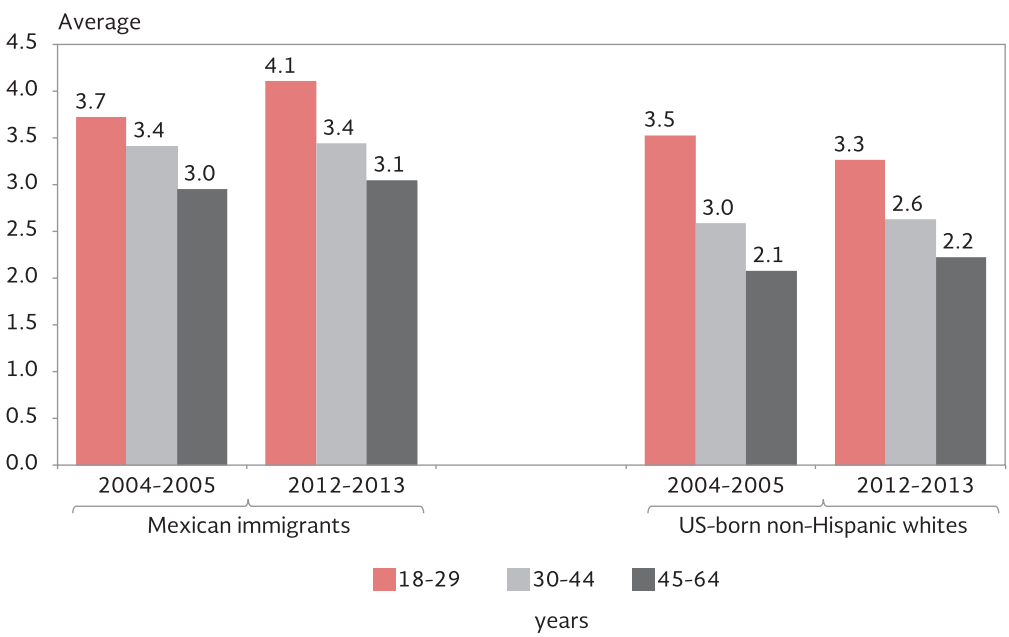
The data show a downward trend in smoking over time for all groups (Figure 46). The smoking rate for Mexican immigrants (11%) is about half that of African-Americans and non-Hispanic whites (20% and 19% respectively). Only Central Americans have lower

Figure 44. Population ages 18 to 64 living in the United States by average consumption of alcohol, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013



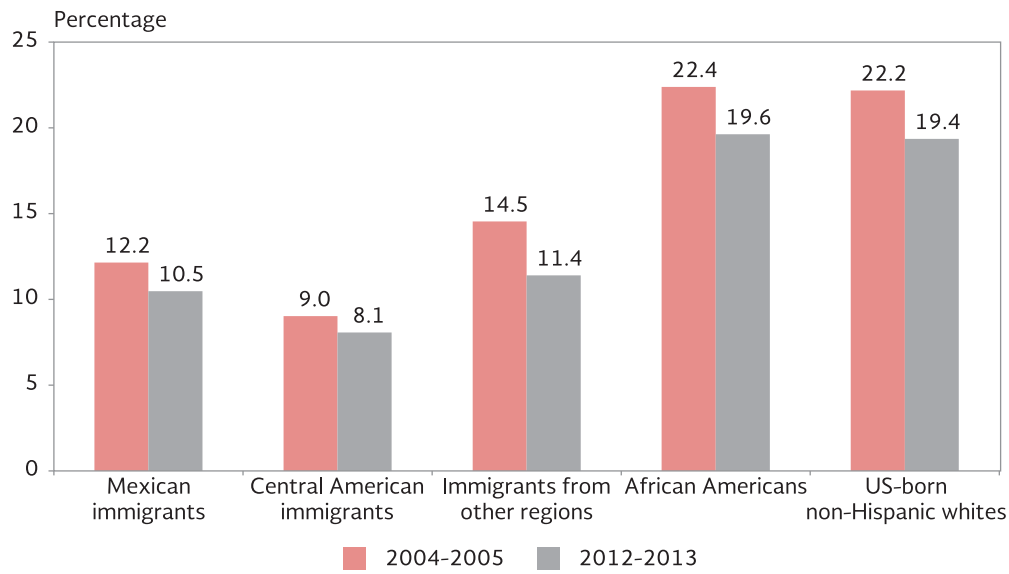
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 45. Population living in the United States by average consumption of alcohol per occasion, based on age group and region of origin, ethnicity or race, 2004-2005 and 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 46. Population ages 18 to 64 living in the Unted States that currently smokes, by region of origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Estimates by CONAPO, based on *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

smoking rates (8%). These trends present an improvement in the health risk profile for Mexican and Central American immigrants and an advantage over the US-born population.

Among Mexican immigrants, the greatest decline in smoking was recorded among 30 to 44 year-olds (Figure 47). That age group now has the lowest smoking rates among Mexican immigrants.

In 2012-2013, daily cigarette consumption among Mexican immigrants who smoked was half that of US-born non-Hispanic whites (7.4 and 15.2 cigarettes, respectively), while there was a difference of one cigarette between occasional smokers of both origins (Figure 48). Especially for regular smokers, the much lower number of cigarettes smoked per day by Mexican immigrants provides a modest health risk advantage.

Health conditions

Children

Hispanic children are very similar to non- Hispanic whites in their rates of hospital admissions for diabetes complications

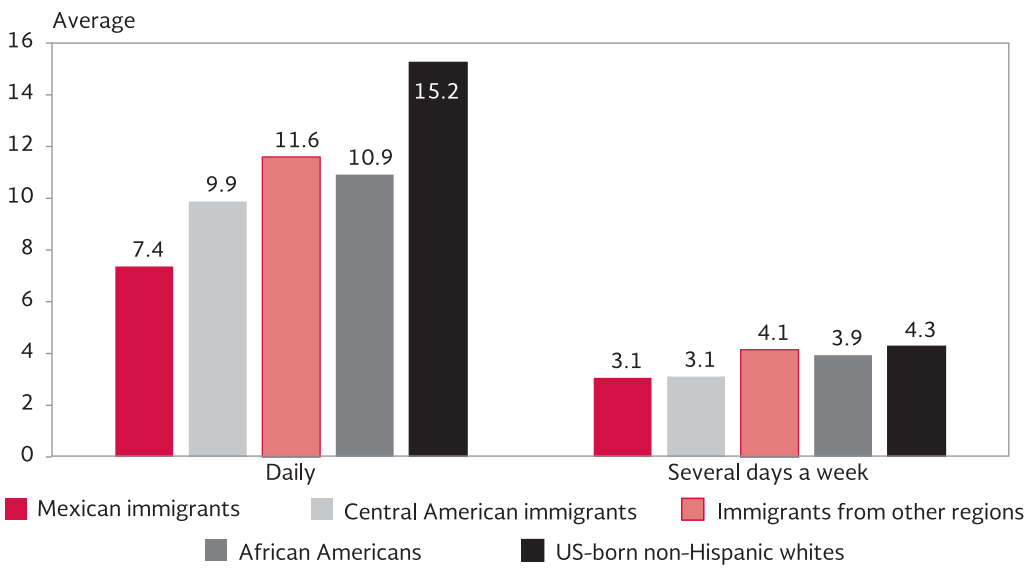
In recent years, diabetes has increased among children and adolescents, and Type 2 diabetes mellitus, formerly considered an exclusively adult ailment, has occurred with increasing frequency. Type 2 diabetes is associated with physical inactivity, poor diet and overweight and obesity. These trends are being seen in both wealthy and middle-income countries.

Between 2008 and 2009 in the United States, 18 000 children and adolescents under age 20 were newly diagnosed with diabetes. Among children under ten years, whites and African Americans displayed the highest rates during that period, while among children over age ten the incidence was highest among African Americans and Hispanics (CDC, 2014).

Figure 47. Population living in the United States that currently smokes, by age group, based on region of origin and ethnicity or race, 2004-2005 and 2012-2013

Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 48. Population between 18 and 64 years living in the United States that currently smokes, by average consumption and frequency, based on region of origin and ethnicity or race, 2012-2013



Note: During the period 2012-2013, 48.8% of the Mexican population that smoked did so daily, and the remaining 51.2% did so several days a week.

Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2012-2013.

In 2009, according to data from the Agency for Health Research and Quality (AHRQ), African Americans between ages six and 19 years had the highest rate of hospital admissions for diabetes complications (53 per 100 000), followed by non-Hispanic whites (32 per 100 000), and finally the Hispanic population at 25 per 100 000 (Figure 49). Although Hispanics had the lowest rate of hospital admissions, the differences between Hispanics and non-Hispanic whites was much lower when examined over a ten year period.

Hispanic adolescents have the second highest percentage of treatment for depressive episodes

In 2010, the percent of adolescents receiving treatment for a depressive episode was slightly higher among non-Hispanic whites (41%) than among the Hispanic population (38%), followed by much lower rates for African Americans (23%) (Figure 50).

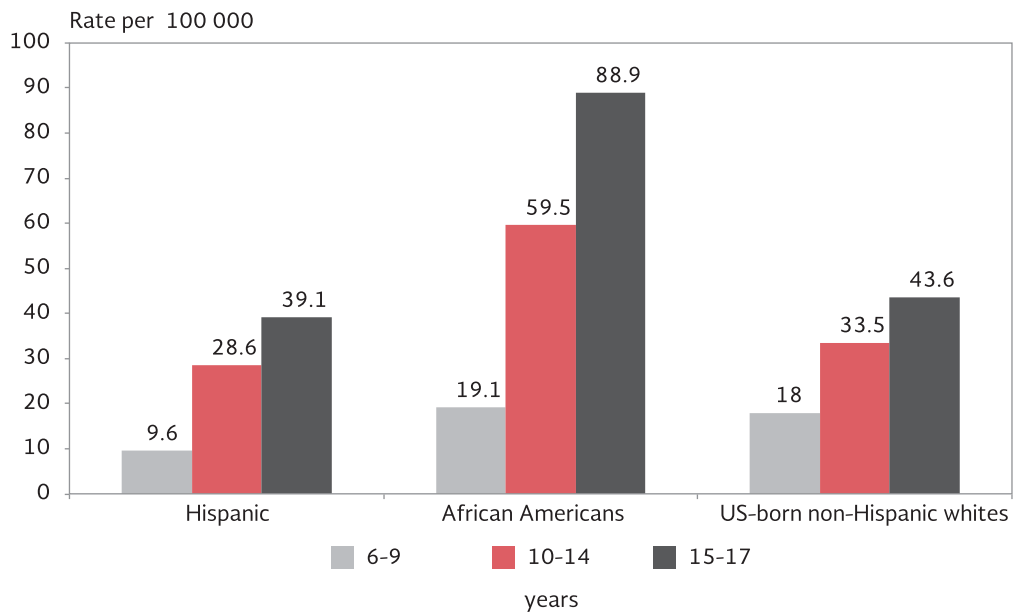
Adults

Mexican immigrants display the lowest percentage of heart disease, cancer and hypertension diagnosed by a health professional in comparison to other groups (Figure 51). Nonetheless, this could be partly a reflection of their lower use of medical services that leads to lower rates of diagnosis, rather than an indication of lower disease rates. In addition, Mexican immigrant adults are younger than the US-born population, and each of these conditions becomes more common with increasing age.

Mexican adults reported the highest increase in persons diagnosed with diabetes

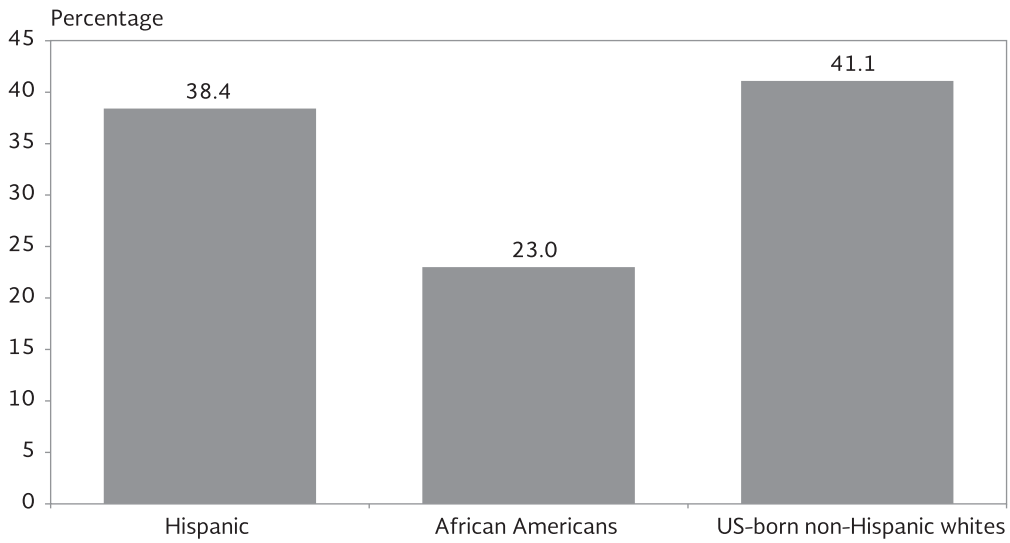
Diabetes, which is directly related to overweight and physical inactivity, is a growing problem among the Mexican and Hispanic populations. The percent of diagnosed diabetes among Mexican immigrant adults (8.1%) is only lower than that of African Americans

Figure 49. Minors in the United States having been admitted to hospital for diabetic complications, by age group and ethnicity or race, 2009



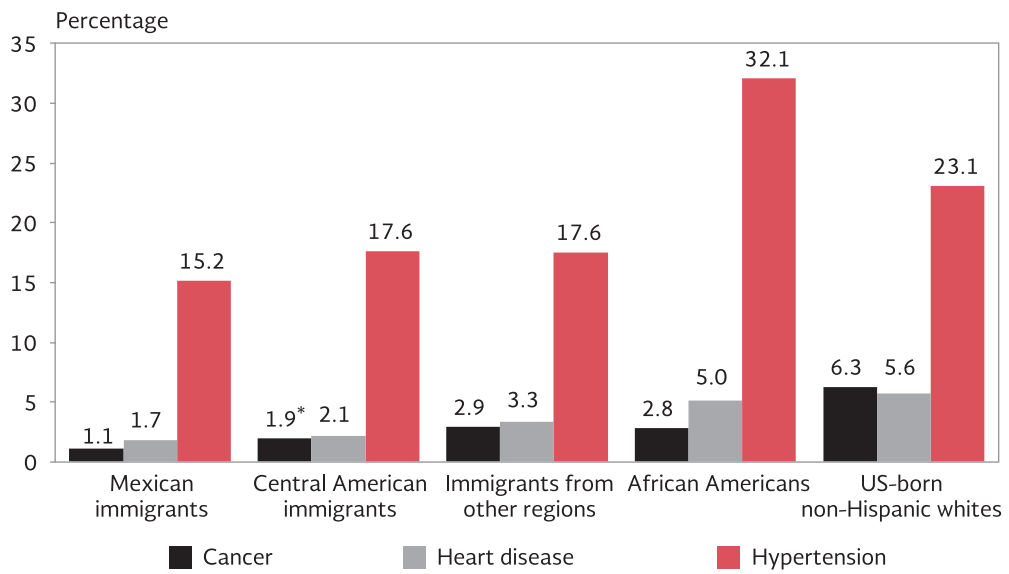
Source: Produced by CONAPO, based on the Agency for Healthcare Research and Quality, 2009.

Figure 50. Population ages 12 to 17 in the United States having received treatment for depressive episodes, by region of origin and ethnicity or race, 2010



Source: Produced by CONAPO, based on the Agency for Healthcare Research and Quality, 2009.

Figure 51. Population ages 18 to 64 in the United States diagnosed with Cancer, Heart Disease or Hypertension, based on region of origin and ethnicity or race, 2012-2013



Note: * Estimate based on under 30 sample cases.
Source: Migration Policy Bureau, SEGOB, based on U.S. State Health Access Data Assistance Center, *National Health Interview Survey* (NHIS), 2012-2013. Integrated Health Interview Series. Minneapolis: University of Minnesota.

(11.3%). Mexican immigrants also had the second highest increase in the proportion of their group with diabetes between 2004-2005 and 2012-2013, after African Americans (Figure 52).

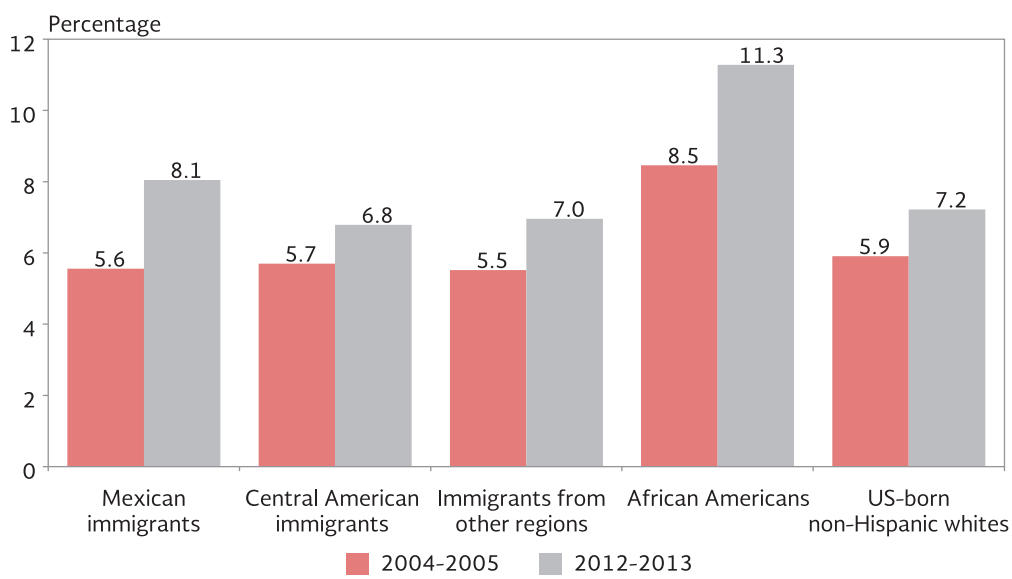
Across all population groups, diabetes is most frequently diagnosed in the 45 to 64-year-old age group. Indeed, 17% of Mexican immigrants in that age group report a diagnosis of diabetes, a proportion only exceeded by that of African Americans (19%) (Figure 53).

Among the immigrant population, length of residence in the United States is a key determinant in the diagnosis of diabetes. Although most of those were not suffering from the illness when they arrived in the US, for others it was not detected until complications appeared. For the majority of those who migrated without diabetes, they encountered additional risk factors in the US including changes in their socioeconomic level, diet, and physical activity that increased their risk for the development of the disease.

In the three groups of immigrants, the proportion of working-age adults diagnosed with diabetes is clearly higher among long-term residents than recent arrivals. This can be explained by the older age of those who have lived for over ten years in the United States, but also their improved access to medical services that increases the chances of being diagnosed and their adoption of unhealthy habits in the host country.

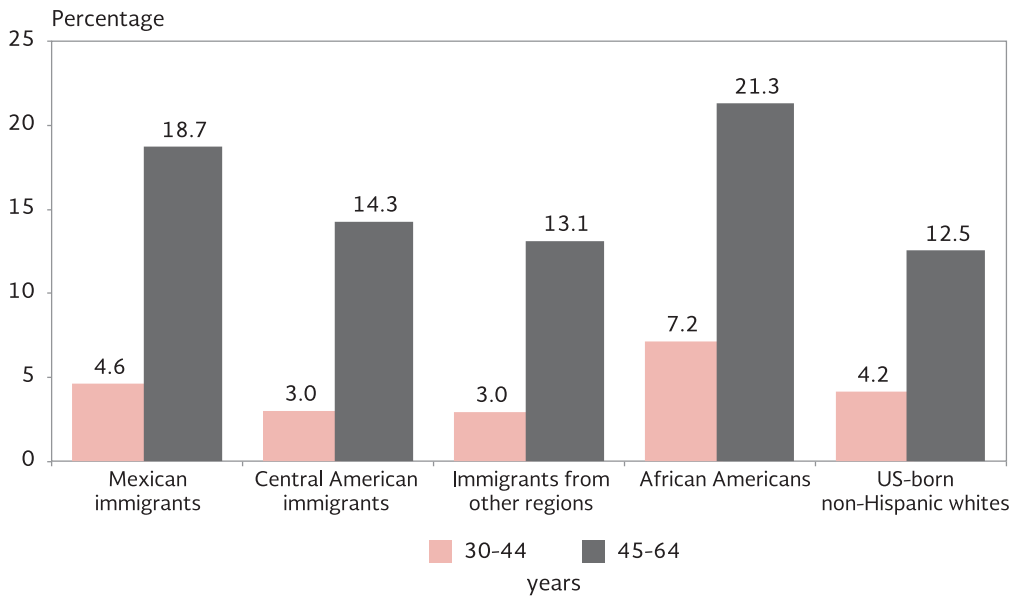
According to data for the period from 2010 to 2013, Mexicans have a higher prevalence of diagnosed diabetes among long-term adult residents (9.6%) than Central American and all other immigrants. On the other hand, among recent arrivals, Mexicans have the lowest percentage of diagnosis (2.3%) (Figure 54).

Figure 52. Population ages 18 to 64 in the United States having been diagnosed with diabetes, by region of origin and ethnicity or race, for periods 2004-2005 and 2012-2013



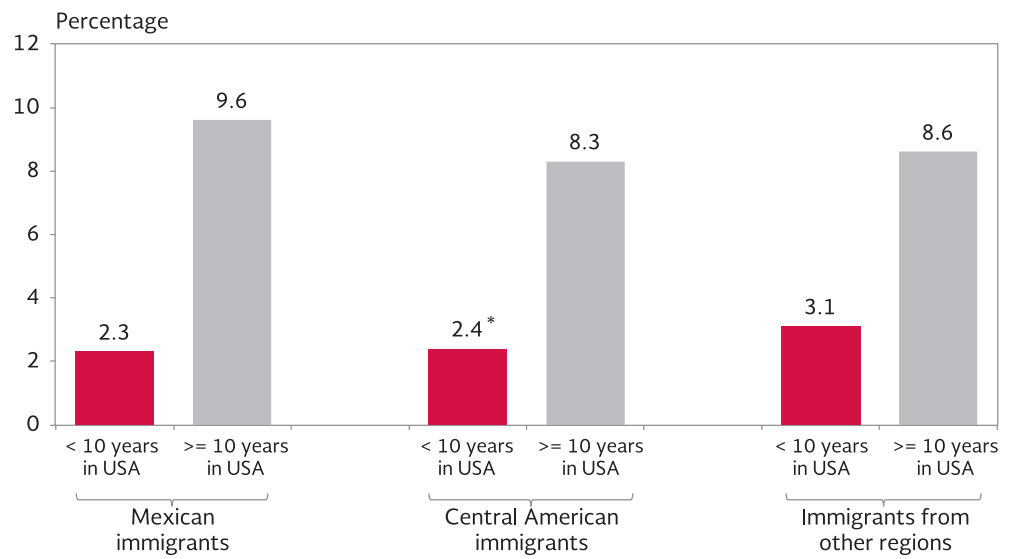
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 53. Population living in the United States having been diagnosed with diabetes, by age group, by region of origin and ethnicity or race, 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2012-2013.

Figure 54. Population between 18 and 64 years in the United States diagnosed with diabetes, based on origin by length of residence during the period from 2010 to 2013



Note: * Estimate based on under 30 sample cases.
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2010-2013.

The Hispanic population has higher rates of detection of new cases of HIV and cervical cancer than US-born whites

In 2009, the Hispanic population displayed higher rates of new cases of HIV cases per 100 000 persons over 13 years old than that of non-Hispanic whites (18.8 and 5.5, respectively). The highest incidence rate was among African Americans (55.2). An analysis by gender shows that men have a higher incidence across all population groups (Figure 55), although it should be noted that it is less common for men to have an HIV test than women as shown in the previous chapter.

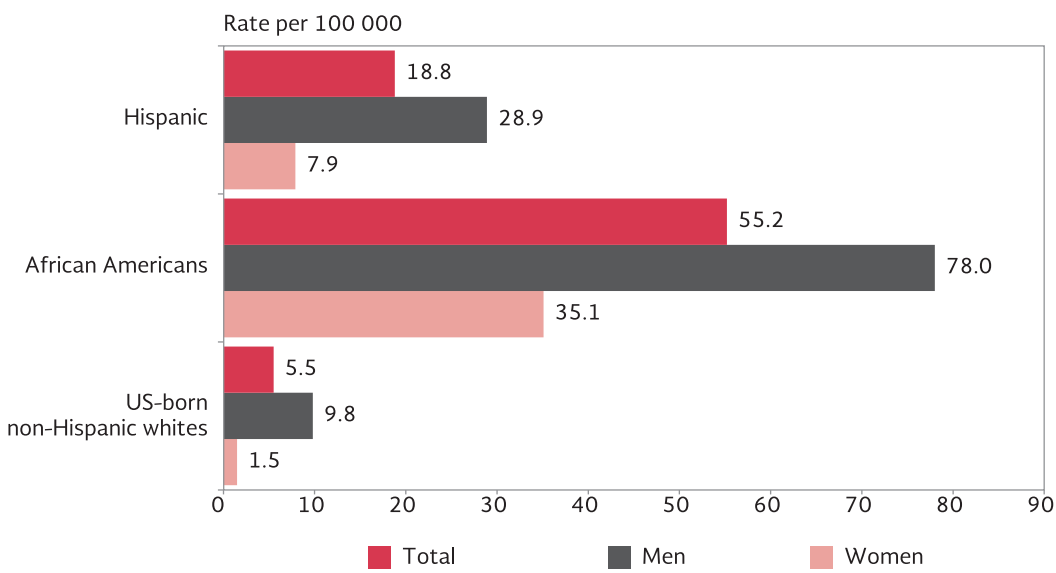
According to the *National Healthcare Disparities Report*, between 2004 and 2008, the Hispanic population displayed the lowest rate of Pap tests within the recommended time frame. This in turn contributes to higher rates of advanced stages of cervical cancer at diagnosis among Hispanic women over 20 years (17.1 per 100 000 persons) (Figure 56).

Older adults

Mexican immigrants and African Americans age 65 and over have the highest rates of diagnosed diabetes

It is crucial to know the health conditions faced by Mexican older adult immigrants, as some are undocumented and cannot obtain health coverage, while many more live on inadequate incomes, making it difficult for them to seek treatment. Moreover, many immigrant workers delay preventive and timely care, which increases the likelihood of diseases at later ages.[2]

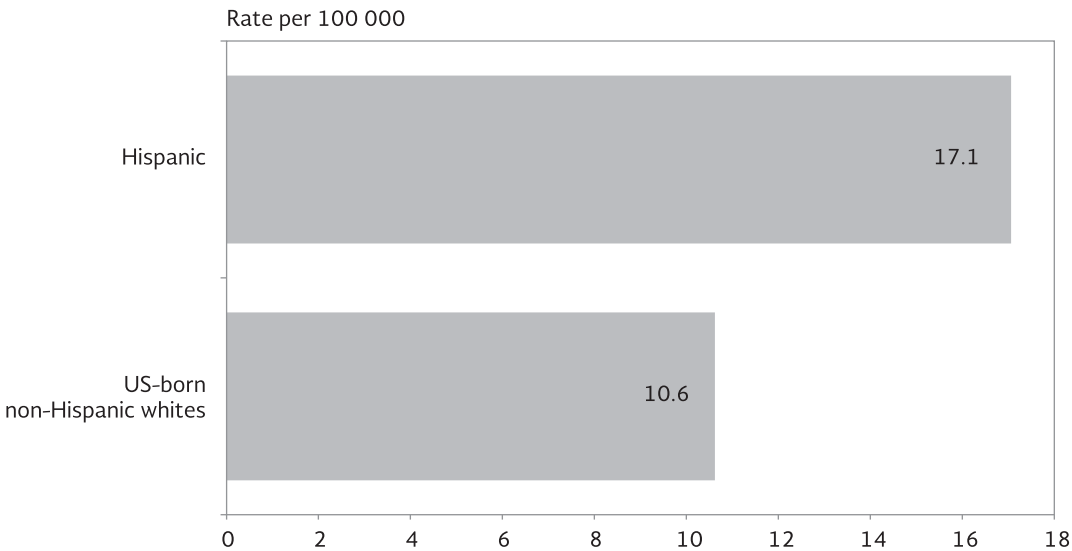
Figure 55. Population over 13 years among new cases of HIV, by gender and based on region of origin and ethnicity or race, 2009



Source: Produced by CONAPO based on the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), HIV/AIDS of the Agency for Healthcare Research and Quality, 2009.

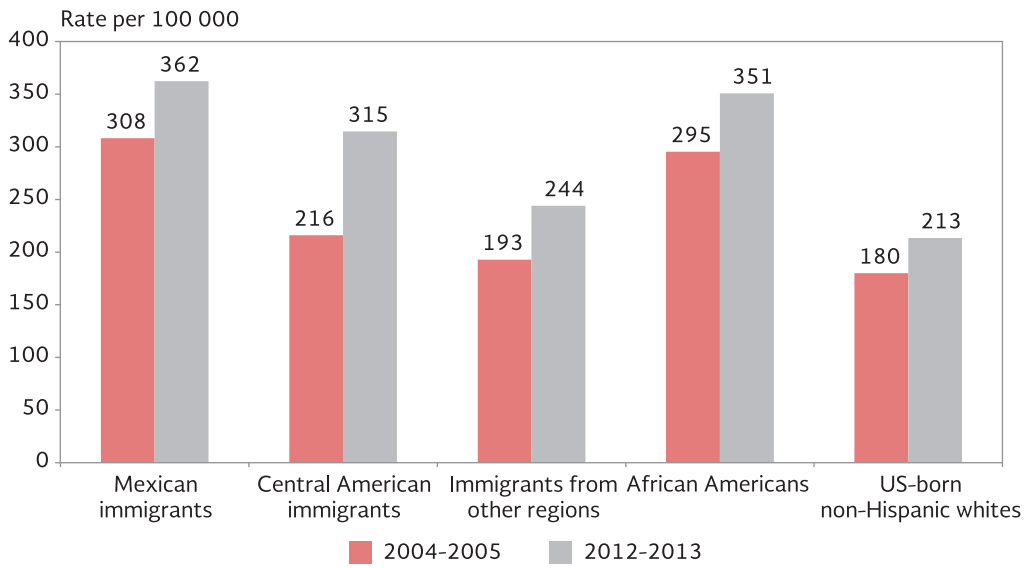
[2] A recent study states that half of short-term Mexican migrants in this age group are unknowingly suffering from the illness (Barcelo *et al*., 2012). Another study indicates that this is directly linked to the period of time spent in the United States, and that a longer stay tends to undermine the health advantages of immigrants in comparison with US-born population (López and Golden, 2014).

Figure 56. Women over age 20 living in the United States having been diagnosed with an advanced stage of cervical cancer, by region or origin and ethnicity or race, 2004-2008



Source: Produced by CONAPO based on the Centers for Disease Control and Prevention and the National Cancer Institute, National Program of Cancer Registries, United States Cancer Statistics, at the Agency for Healthcare Research and Quality, 2004-2008.

Figure 57. Population over 65 years living in the United States having been diagnosed with diabetes, by region of origin and ethnicity or race, 2004-2005 and 2012-2013



Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

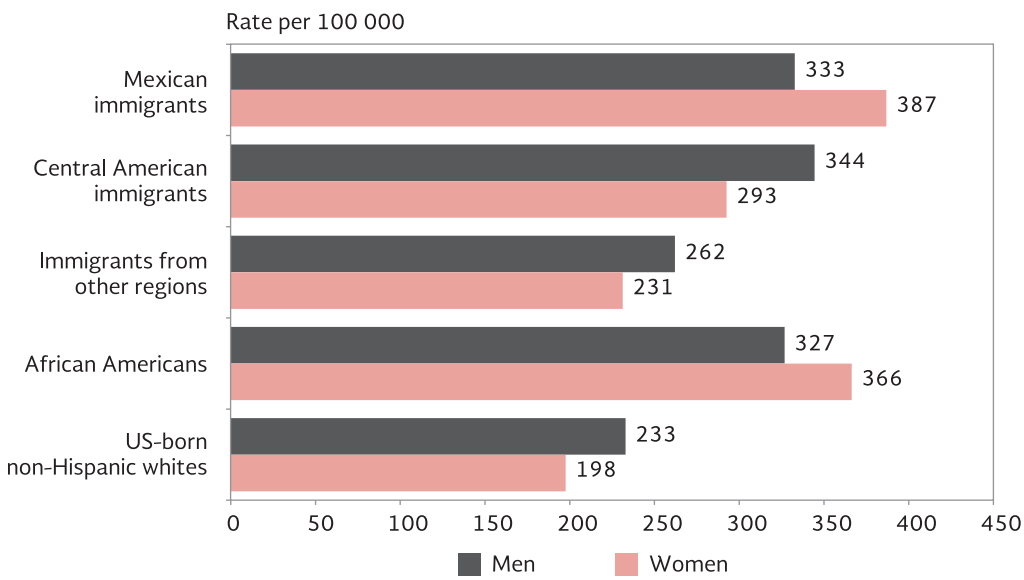
During the 2012 to 2013 period, Mexicans and African Americans had the highest rates of diabetes diagnosis, with 362 and 351 per 1 000 respectively, far higher than that of non-Hispanic whites (213 per 1 000) (Figure 57). This is a priority issue since the limited access to health services experienced by Mexican immigrants reduces their access to timely diagnosis and adequate treatment, which is exacerbated by economic, social and language barriers.

Moreover, elderly Mexican immigrant and African American women display a higher prevalence than men, whereas in other groups, the situation is reversed. Importantly, Mexicans and Central Americans have the greatest gender gaps out of the five population groups (54 and 51 per 1 000, respectively) (Figure 58).

Women experience more difficulty than men in performing daily activities in old age

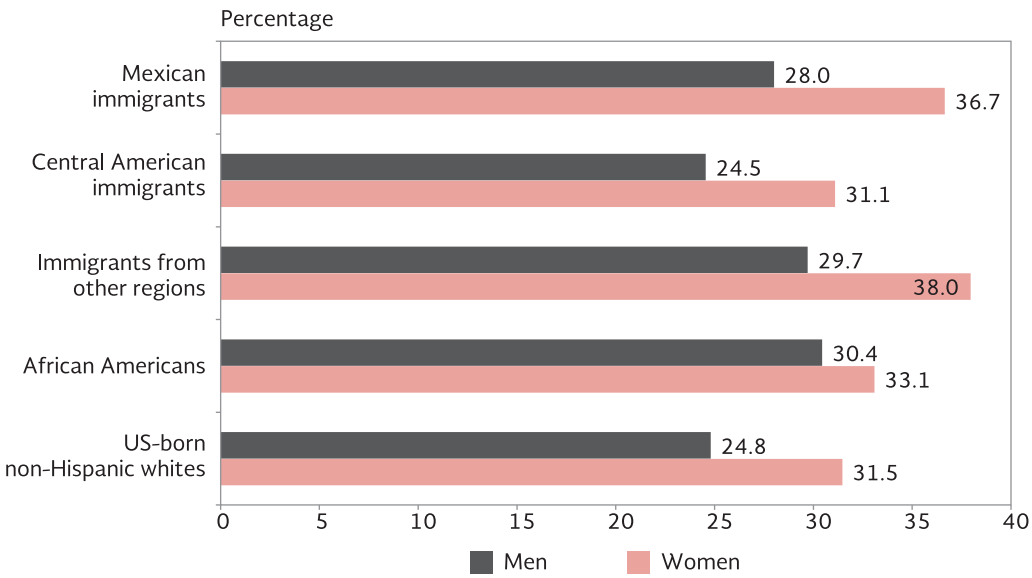
In 2012-2013, across all population groups, women over 65 had a higher rate of functional limitations than men over 65. Mexican immigrant women have the second highest rate of functional limitations (37%) after other immigrants (38%), and the rate for Mexican immigrant men (28%) is lower than African Americans and other immigrants, but higher than that of US-born non-Hispanic whites (25%). Mexicans have the highest gender gap of all the five population groups (8.7 percentage points) (Figure 59).

Figure 58. Population over age 65 living in the United States having been diagnosed with diabetes, by gender, based on region of origin and ethnicity or race, 2012-2013



Source: Estimates by CONAPO, based on *National Health Interview Survey* (NHIS), 2012-2013.

Figure 59. Population above 65 years living in the United States, with a functional limitation,* by gender, based on region of origin and ethnicity or race, 2012-2013



Note: * Functional limitation refers to a physical, mental or emotional health problem or illness.
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2012-2013.

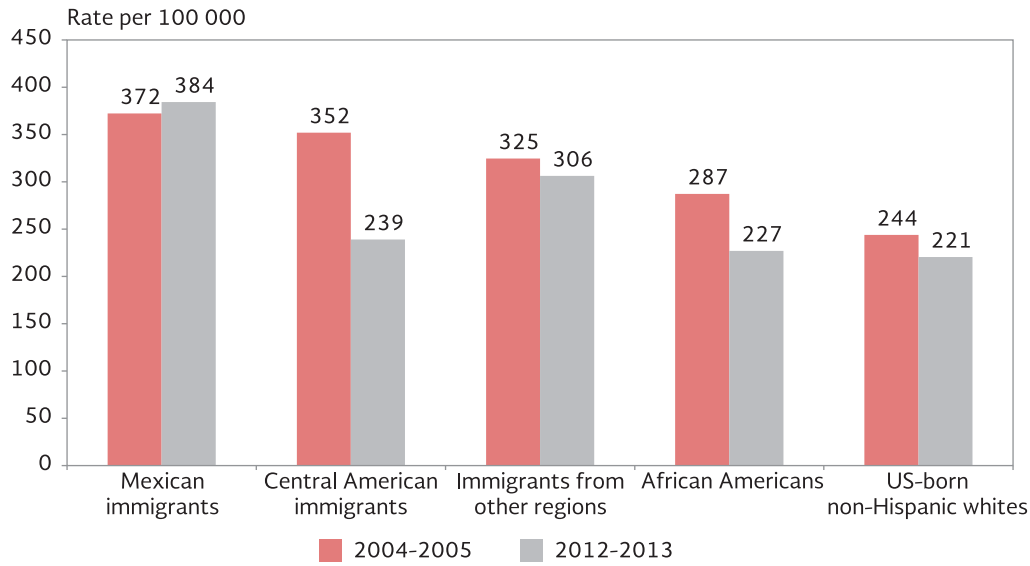
Mexican immigrants age 65 and over living in the United States have the highest rate of feeling sad

Persistent sadness, mourning or melancholy indicates depression, a condition that is insufficiently diagnosed since it is often overlooked when patients present with other physical and mental ailments (Sánchez *et al*., 2008).

All immigrants report the highest rates of experiencing sadness in the past 30 days, both in 2004-2005 and 2012-2013, while Mexican immigrants have the highest rate of 384 per 1 000 persons. There has been a slight increase among Mexicans, while the four other groups saw decreases, particularly among Central Americans, which has placed them at a nearly similar level to the US-born population in the most recent period (Figure 60).

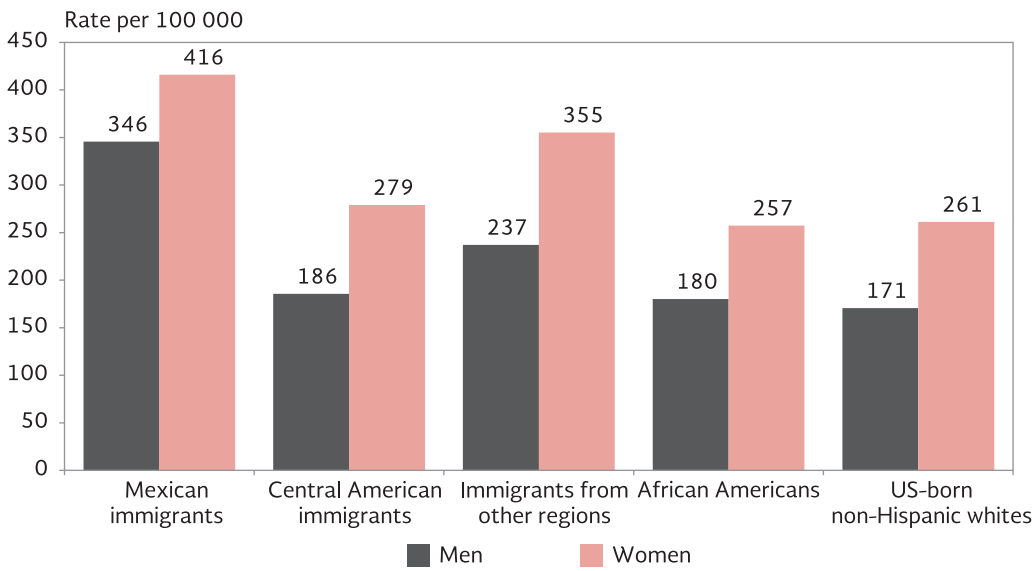
Across the five groups, women have a greater tendency to feel sad than men, although Mexicans display the smallest gender gap (Figure 61).

Figure 60. Population above 65 years living in the United States that has felt sad in the previous year,* by region of origin and ethnicity or race, 2004-2005 and 2012-2013



Note: * Persons who felt rarely, occasionally, often or constantly sad in the 30 days previous to the interview.
Source: Estimates by CONAPO, based on the *National Health Interview Survey* (NHIS), 2004-2005, 2012-2013.

Figure 61. Population above 65 years living in the United States that have felt sad in the previous year,* by gender, based on region of origin and ethnicity or race, 2012-2013



Note: * Persons who rarely occasionally, often or constantly felt sad during the 30 days previous to the interview.
Source: Estimates by CONAPO, based on the *National Health Interview Survey*, 2012-2013.

Conclusions

The results of this chapter show that despite positive indicators for certain health conditions and health risk factors over the past ten years, the poor health of Mexican immigrants in terms of certain diseases, particularly diabetes, is of concern. Given the low socioeconomic level, low rates of access to care and the aging of this population, immediate efforts are required to prevent further deterioration in health.

Overall, there has been improvement in the health risk profile for Mexican and Central American immigrants in terms of decreases in smoking rates. Mexican immigrant adults also enjoy lower rates of cardiovascular disease, cancer and hypertension. However, diabetes is a condition that supposes a significant current threat to health, as Mexican immigrant adults are the group for which diagnosis of this condition is increasing most rapidly. It is also problematic that Mexican immigrant adults over 65 make up the group with the highest rates of diabetes, as they are also more likely to live with low incomes and lack health care. And for newly arrived migrants, changes adopted in the host country put them at increased risk for developing the disease in future years. With the relationship of diabetes to other chronic diseases, these trends point to a growing public health problem that needs addressing. Improvement in prevention, diagnosis and treatment of the disease can be more successful if carried out in conjunction with improvements in health insurance coverage and access to quality care for the immigrant population.

Chapter IV
Fertility and mortality among the hispanic population

Introduction

Migration is one of many factors of demographic change which, together with mortality and fertility, can affect the growth and composition of the population. This chapter presents information on fertility and mortality rates, in addition to other key indicators, based on vital statistics.[1] These rates are also often used as an indicator of well-being and health status of the population, this chapter further analyzes the principal causes of death that can provide insights into the health of immigrant and other population groups in the United States, as well as their need for health services.

The data used to calculate vital statistics[2] are based on the inter-censal estimates produced since 2000 by the National Center for Health Statistics (NCHS) in collaboration with the National Cancer Institute (NCI) and the United States Census Bureau. These institutions use data on ethnicity and origin in their estimates, when the estimate considers origin; it not only recognizes a person's place of birth, but also his heritage, nationality and descent. Using these criteria, this chapter identifies the principal changes in fertility and mortality among the Hispanic, non-Hispanic African American and non-Hispanic white population. In the case of the Hispanic population, the analysis focuses on persons of Mexican, Central American and South American origin. The degree of specificity and the period of analysis depend on the information provided by the NCHS.

Fertility

Since 2007 there has been a decline in total births, particularly among Mexican mothers

The period between 2004 and 2007 saw an increase in total births across all the population groups, however after 2007 there was a downward trend, and by 2012 the largest decrease was recorded among Mexican women (23%), almost equal to Central and South American women[3] (22%). The decline in total births was lower in non-Hispanic whites (8%) and non-Hispanic African Americans (7%) (Figure 62).

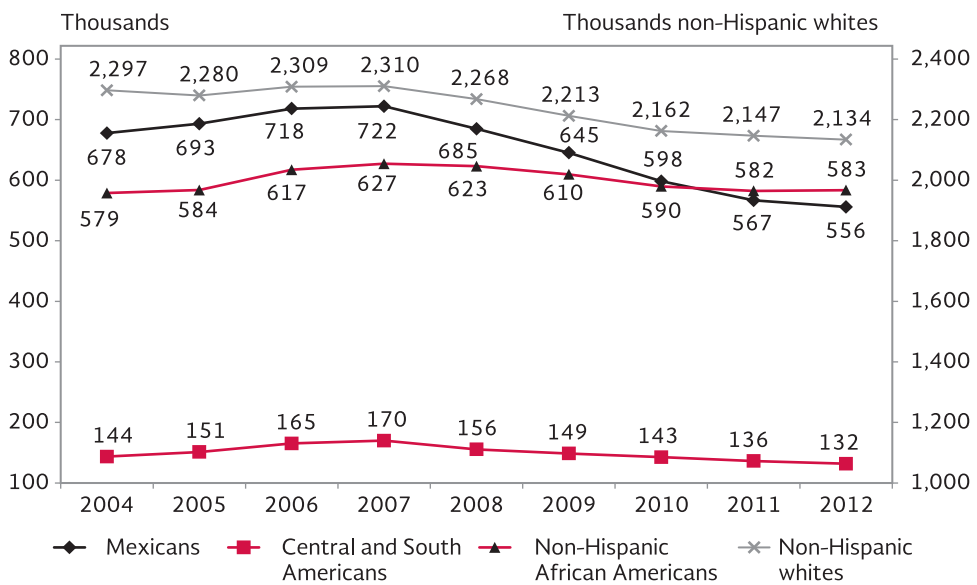
Two states alone, California and Texas, account for approximately six out of ten births to Mexican mothers. There was no significant change in the geographic distribution in those births between 2004 and 2012 (Figure 63).

[1] In the United States, each state is responsible for recording vital statistics. These jurisdictions (50 states, five territories and two cities) are tasked with recording the information, taking minutes and sending copies of these to citizens. The Federal Government publishes these vital statistics through the National Vital Statistics System (NVSS), and data are provided by NCHS and local civil registry offices.

[2] For more details about the indicators used in this chapter see the definitions of the National Association for Public Health Statistics and Information Systems (NAPHSIS) in http://www.naphsis.org/Pages/StatisticalMeasuresandDefinitions.aspx

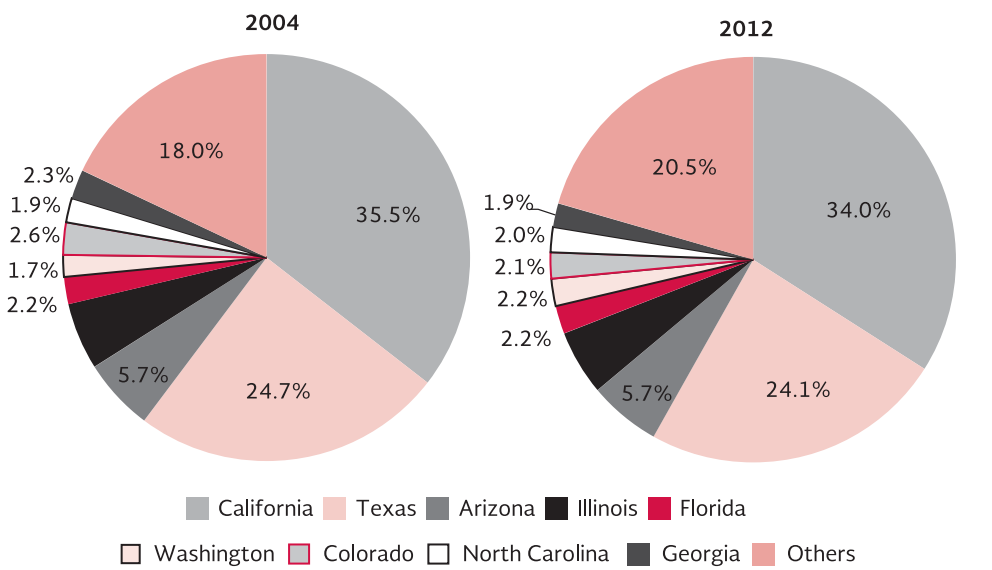
[3] These are presented as a single population group (the Central and South American).

Figure 62. Total births in the United States, by origin and ethnicity or race of mother, 2004-2012



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Figure 63. Percentage distribution of live births born to mothers of Mexican origin, by US States, 2004 and 2012



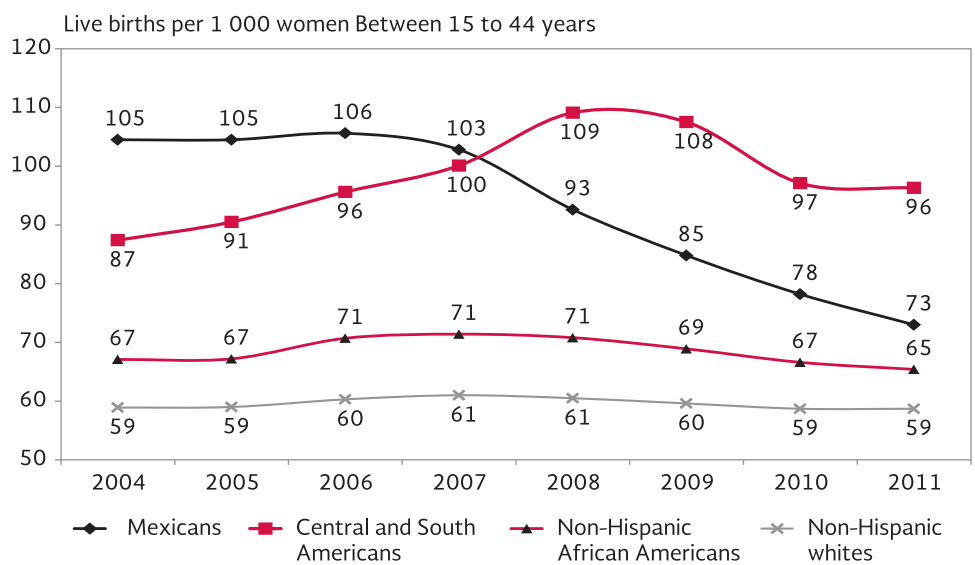
Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Mexican mothers have reduced their fertility for the period 2004-2011

The general fertility rate of Mexican women dropped considerably, from 105 live births per 1,000 women in 2004 to 73 in 2011. Conversely, the rate among Central and South American women increased from 87 to 96 live births over the same period. Among non-Hispanic African American and non-Hispanic white women the trend was more stable (Figure 64).

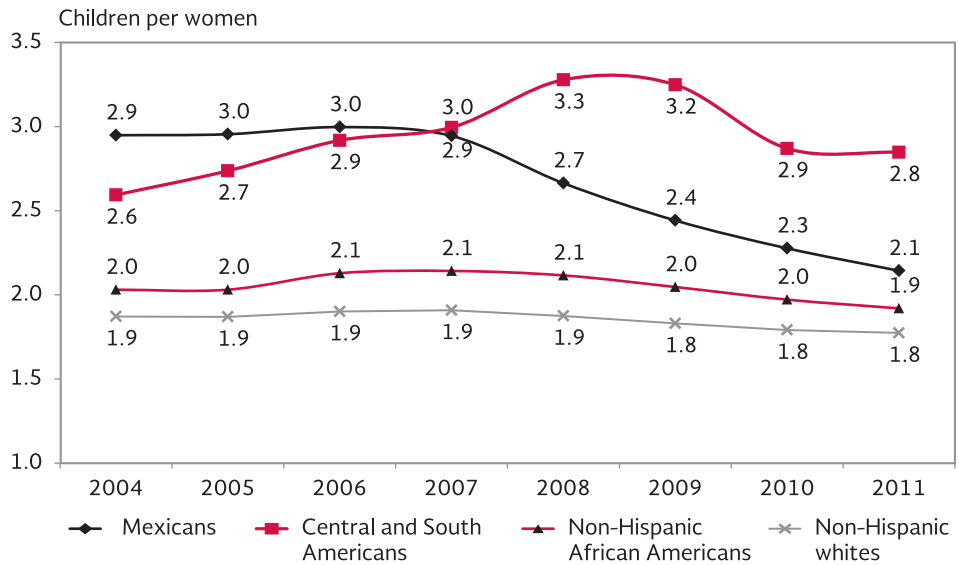
The total fertility rate among Mexican women fell by almost one child, from 2.9 children per women in 2004 to 2.1 in 2011, a decrease that seem excessive, and that need greater studies to explain it. The only group that showed an increase was Central and South Americans, where rates rose from 2.6 to 2.8 children per woman (Figure 65).

Figure 64. General fertility rate in the United States, by origin and ethnicity or race of mother, 2004-2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Figure 65. Total fertility rate in the United States, by origin and ethnicity or race of mother, 2004- 2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Mexican women have reduced their likelihood of becoming mothers at an early age

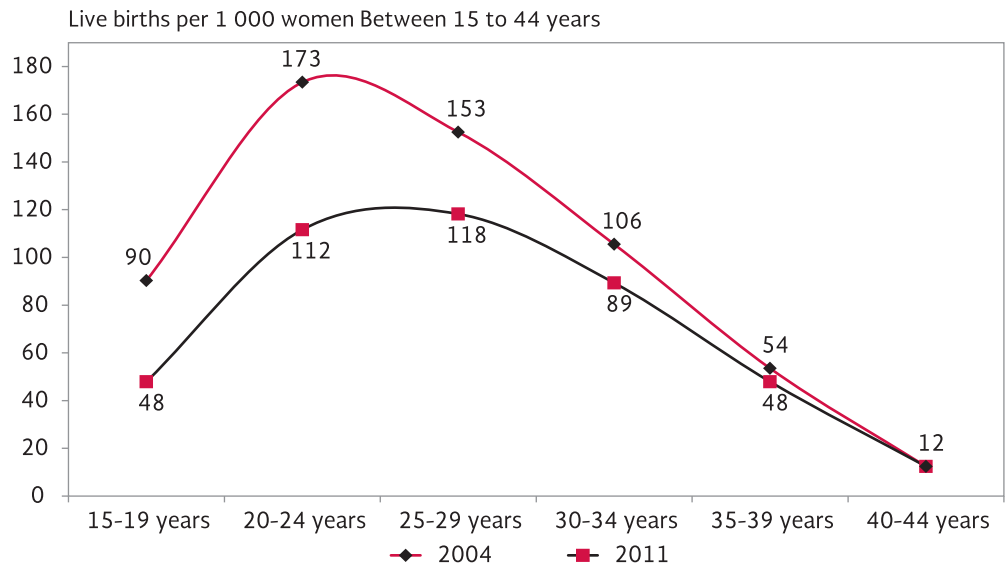
Significant changes took place in the specific fertility rates by age group for women of Mexican descent in the period between 2004 and 2011. Whereas in 2004 the fertility structure was characterized by an early peak curve, with the highest fertility among 20 to 24-year-olds (112 births per 1,000 women), by 2011 it had become a dilated peak curve, typical of populations with a low fertility rate, with the highest fertility among 20 to 24-year-olds and 25 to 29-year-olds (112 and 118 births per 1,000 women, respectively) (Figure 66). During the same period, the fertility rate for Mexican adolescents of Hispanic origin fell from 90 to 48 births per 1,000 women. This speaks of the decline of motherhood in the number of teenagers and young Mexican women.

In the case of women ages 30 to 44, although their fertility rate decreased, this did not happen as quickly as among younger age groups (Figure 66). The reduction in birth and fertility rates can be attributed, among other factors, to the adoption of the predominant reproductive pattern of the host society as well as the replication of the reproductive pattern of the society of origin since these rates are also falling in Mexico and the decrease in the migratory flow (PHC, 2011).

The average age at which Mexican women have their first child increased by almost a year

The change in Mexican women's fertility patterns is also reflected in the average age at which their first child is born. Over the past nine years, Mexican, Central American, South American and African American women have delayed the birth of their firstborn by almost a year. In 2012, Mexican and African American women had the youngest average ages of becoming first-time mothers (23.2 and 23.6 years, respectively), followed by Central American and South American women and non-Hispanic white women, who had an average age that was three years older (26.2 and 26.6 years, respectively) (Figure 67).

Figure 66. Specific fertility rate by age group among women of Mexican Origin in the United States, 2004 and 2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Another factor that changed significantly is the mothers' marital status at the birth of the first child. After 2004, the percentage of unmarried women increased across almost all population groups. In 2012 half of Mexican, Central American and South American women were unmarried or cohabiting when their first child was born. Conversely, seven out of ten African Americans and only three out of ten non-Hispanic white women were unmarried (Figure 68).

Mortality

The Hispanic population has lower mortality rates than the African American and non-Hispanic white population

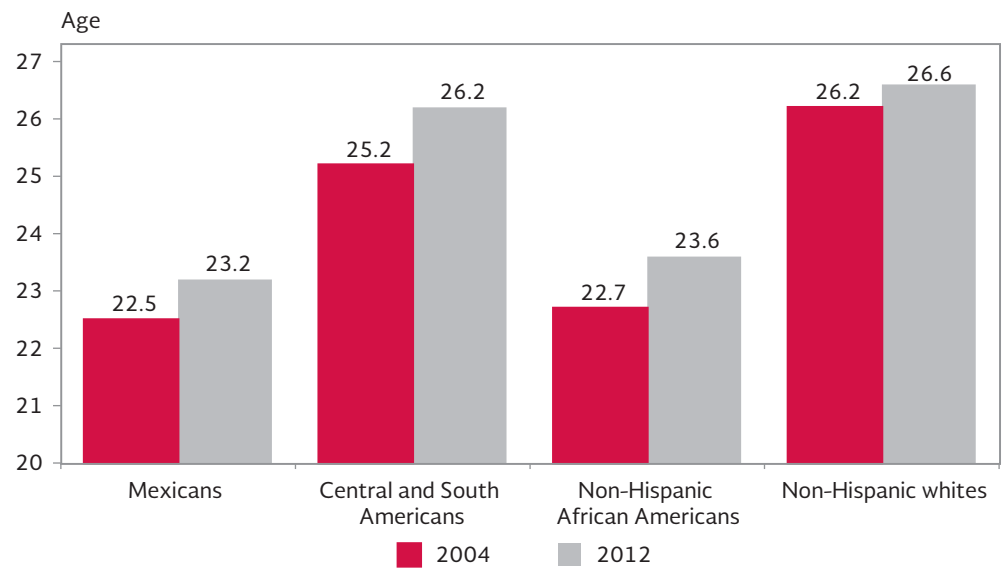
Between 2004 and 2011, the total number of deaths among the Hispanic population increased by almost 22%, whereas the rise among the non-Hispanic white population was only 3.8% and the rate remained relatively stable among African Americans (Figure 69). However, adjusted mortality rates show a decrease in mortality among almost all population groups, 15.2% among African Americans (from 1 063 to 902 per 100,000 people), 12.3% among Hispanics (from 617 to 541 per 100 000 people) and 6.7% among non-Hispanic whites (from 808 to 754 per 100 000 people) (Figure 70).

The incidence of the four leading causes of death is lower among Hispanics than non-Hispanic whites, with the exception of diabetes mellitus

Four important causes of death in the United States for the period from 2008 to 2010 are cardiovascular diseases, cancers, diabetes mellitus and non-intentional lesions.[4] The Hispanic population has the lowest mortality rates across all age groups, both for cardio-

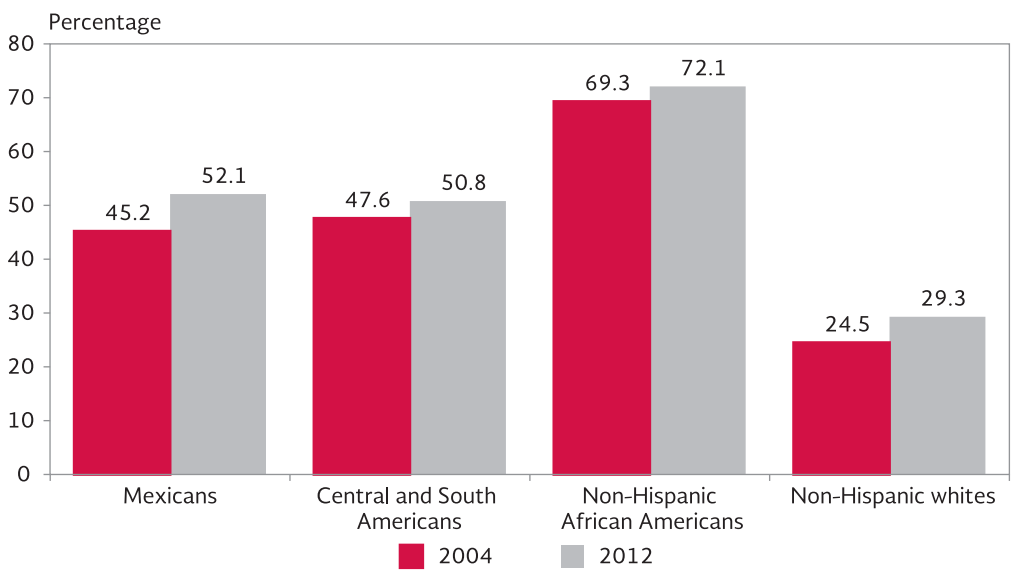
[4] Since persons under 55 have very low rates of death caused by illness, only the age groups in which the differences between population groups can be perceived more clearly are shown.

Figure 67. Average age of mother when giving birth to first child in the United States, by origin and ethnicity or race, 2004 and 2012



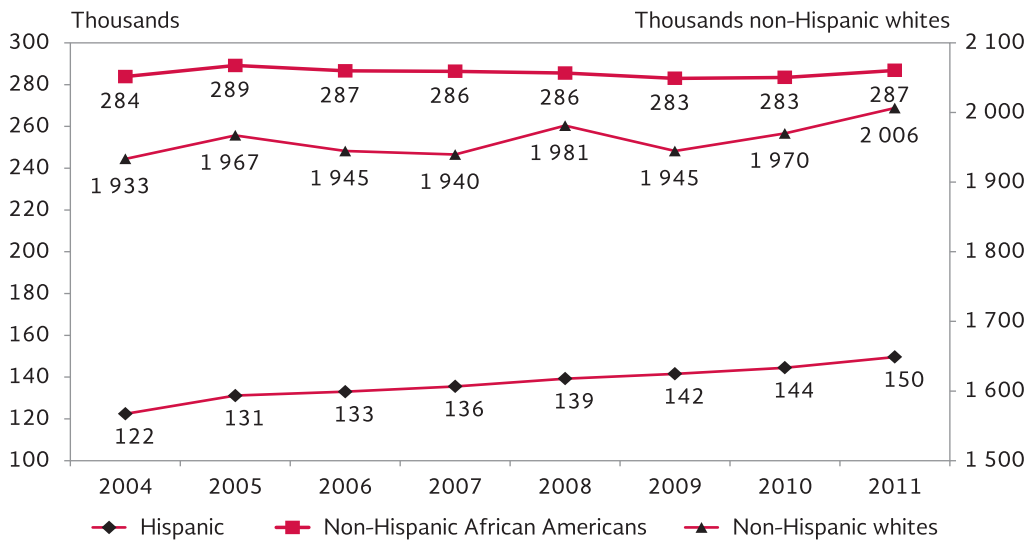
Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Births, 2012.

Figure 68. Percent of mothers who are unmarried when giving birth to their first child, United States, by origin and ethnicity or race, 2004 and 2012



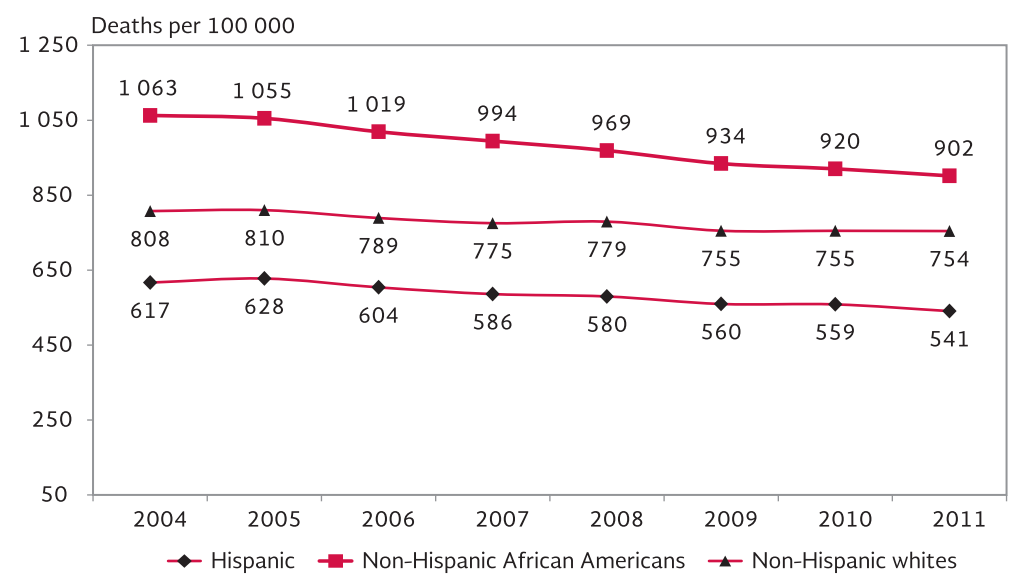
Source: Produced by CONAPO based on data from Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), National Vital Statistics System, Births, 2012.

Figure 69. Total deaths in the United States, by origin and ethnicity or race, 2004-2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2011.

Figure 70. Adjusted death rate in the United States, by origin and ethnicity or race, 2004-2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2011.

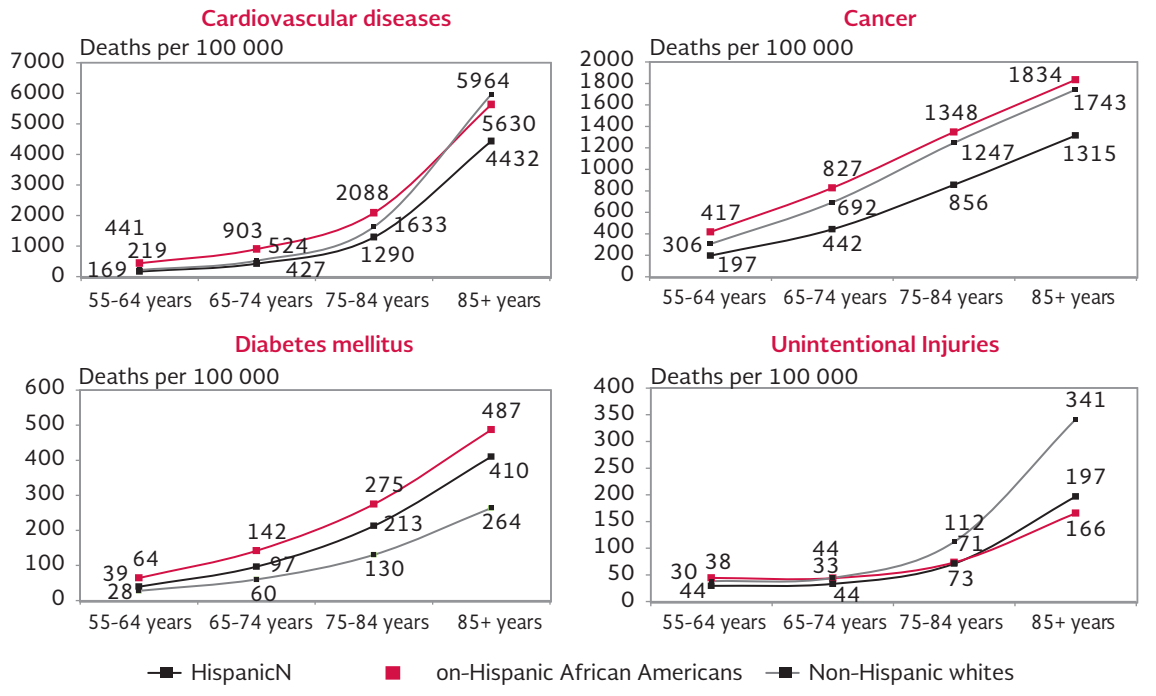
vascular diseases and cancers, and are only higher than those of African Americans for unintentional injuries for this age group. However, they have the second highest rate of diabetes mellitus, after African Americans (Figure 71).

The prevalence of diabetes mellitus among the Hispanic population represents a severe health problem, since after the age of 55 it exceeds the mortality rate of the white population, a gap that increases with age. The difference for the age group 75 to 84 years is particularly striking, as diabetes accounts for 213 deaths per 100 000 persons, while for whites it is only 130 deaths. The magnitude of this gap is maintained in the oldest age group (85 and above), where Hispanics have a rate of 410 deaths per 100 000 persons, compared to 264 deaths for the non-Hispanic white population (Figure 71). This situation can be explained by a combination of factors, including the high percentage of overweight persons in the Hispanic community, insufficient physical activity, higher alcohol consumption and a lack of adequate primary medical care management following the diagnosis, which the Hispanic population shares with African Americans. Diabetes risk factors, including poor diet, lack of diagnosis and timely care, and unhealthy lifestyles, are highest among those with the lowest incomes (PHC, 2002).

The leading causes of infant deaths among the Hispanic population are congenital anomalies

During the period 2002-2004 and 2008-2010, there has been a decrease in infant mortality rates in all population groups, though the decline was less in the Hispanic population (3.9%) and the highest was in the African American population (11%). In contrast, in the non-Hispanic white population the decline was 6.6% (see Figure 72).

Figure 71. Principal causes of mortality among the population above 55 Years in the United States by age groups, by origin and ethnicity or race, 2008-2010



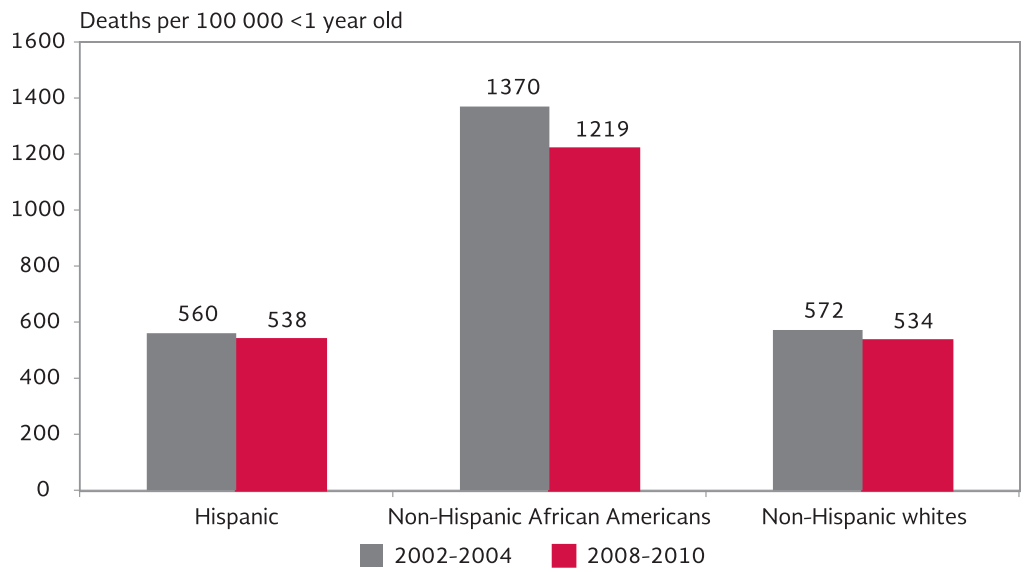
Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2008-2010.

The four leading causes of death among children under one year of age in the United States during the period 2008-2010 are congenital anomalies, premature birth or low birth weight, complications during pregnancy and sudden infant death syndrome. There is a higher prevalence of these four factors among African Americans, while the Hispanic population has higher rates than the non-Hispanic white population for congenital anomalies and premature birth or low birth weight (140 and 87 death per 100 000 births, as opposed to 121 and 73, respectively). In contrast, for complications during pregnancy and sudden infant death syndrome, the non-Hispanic white population has higher rates than the Hispanic population (32 and 53 deaths per 100 000, compared to 31 in both, respectively) (Figure 73).

In 2011, the Hispanic population had a life expectancy at birth of 81.4 years

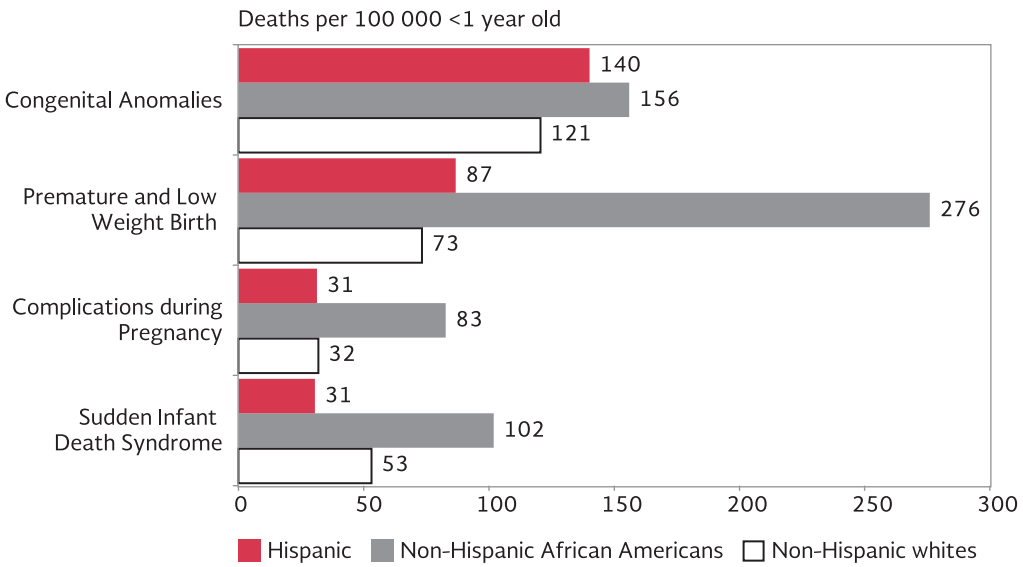
Life expectancy at birth has increased across all the population groups since 2006. In 2011 the Hispanic population had a life expectancy of 81.4 years, 2.6 years more than that of the non-Hispanic white population and 6.5 years higher than that of non-Hispanic African Americans (Figure 74). The difference between life expectancy of Hispanics and non-Hispanic whites is known as the Hispanic paradox.

Figure 72. Infant mortality rate (< 1 year old) in the United States by origin and ethnicity or race, 2002-2004 y 2008-2010



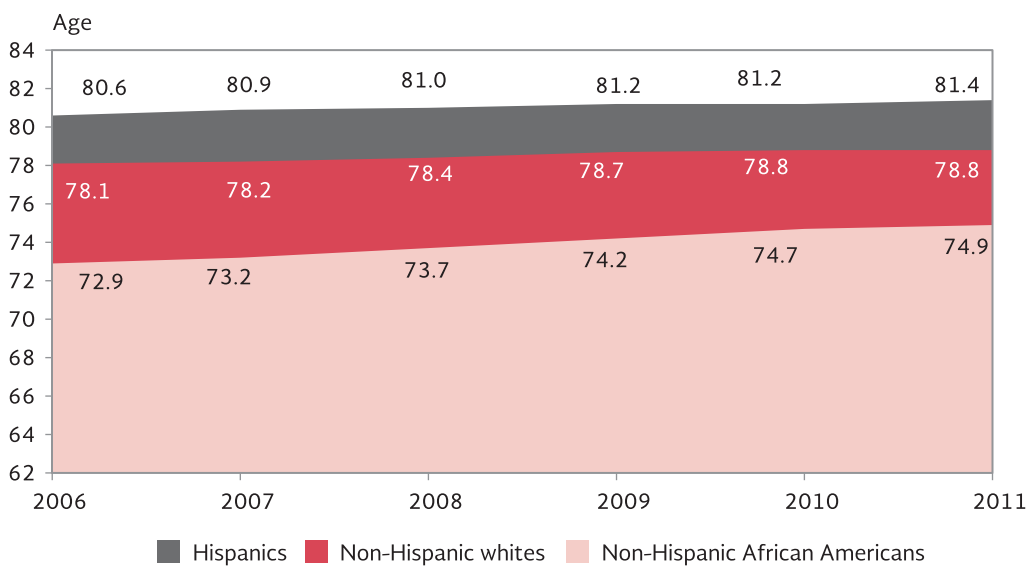
Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2002-2010.

Figure 73. Principal causes of infant mortality (< 1 year old) in the United States, by origin and ethnicity or race, 2008-2010



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2008-2010.

Figure 74. Life expectancy at birth, United States, by origin and ethnicity or race, 2006-2011



Source: Produced by CONAPO based on data from Centers for Disease Control (CDC) and Prevention and the National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Deaths, 2011.

Conclusions

The Mexican-origin population, including both immigrants and people of Mexican descent, until recently had the highest fertility rates of all population groups observed in this study. The decrease is such and so fast than in the last 10 years, and Central and South Americans have higher fertility rates only slightly above that of non-Hispanic African Americans.

Changes in the pattern of fertility of women of Mexican origin mean that the social and cultural contexts in which they operate are changing, since women are reducing their number of children and have their first pregnancy at older ages (though still earlier than non-Hispanic white women). This suggests that families may be able to devote more resources to the education and upbringing of each child. This in turn could be contributing to an improvement in the health conditions of children and could predict better adult health in the coming years.

While Hispanics have the longest life expectancy and overall lowest death rates, they experience a substantial disadvantage in their mortality due to diabetes. Moreover, given risk factors and reduced access to health care, it is important to address these issues through campaigns of care, promoting health and diagnosis, in addition to advocating for better social integration of the Hispanic population in the United States.

Conclusions

The United States hosts the largest number of international migrants with 20% of the global total (over 200 million according to IOM). Currently, Latin Americans in the United States make up accounts for half of the foreign-born population living in the country (21.8 million people); 11.8 million born in Mexico. The number of Mexican origin persons living in the United States totals 34.3 million, including those born in Mexico and the descendants of earlier Mexican immigrants. Their presence has important demographic and social implications for the nation as well as for the world. The Mexican origin population is an important part of the workforce and helps to counter the decrease in the working age population in the United States; they also contribute culturally and linguistically to the diversity of the country, which is one of the most important assets of the nation.

This report analyzes, the trends of the past ten years in Mexican immigration to the United States, focusing on the key areas of health, wellbeing and social integration. The data are presented in comparison with immigrants from Central America, immigrants from other region, African-Americans and the non-Hispanic white population to document the relative advantages and disadvantages they face. These areas have each been covered for single years in previous reports for this series on migration and health. This is the first time trend data has been reported across the topics.

The past ten years have witnessed the increasing dispersion of the Mexican origin population throughout the United States. Mexican immigrants are still concentrated in urban geographic areas, particularly in states along the US-Mexico border, but they are increasingly moving to other parts of the country. The growth of the Mexican origin population in the US is now less related to new immigration, this, due to a reduction of the flow of undocumented, and relies more on the growth of a second generation and subsequent.

Although some health indicators show slight improvement over the past decade, Mexican and Central American immigrant populations are still among the most vulnerable groups in the nation both socially and economically. As in 2004, Mexican and Central American immigrants have the lowest rates of naturalization of all immigrant groups. While poverty increased from 2004 to 2013 among all of the groups studied in this report, Mexican immigrants show the greatest economic deprivation. In the labor market, Mexican immigrants are concentrated in the low-wage sectors, a distribution similar to that of ten years ago. These are key indicators for which Mexican immigrants have shown little improvement over the past decade and which are intricately linked to health in that the likelihood of having health insurance coverage and seeking services is related to citizenship, employment and income level.

In terms of access to health insurance, in 2013 as in 2004, Mexican immigrants in the US did not have adequate health care insurance or access to care. Fifty-two percent of Mexican immigrants in the US did not have health insurance in 2013, and although they represent 4% of the US population, they accounted for 13% of the uninsured population. Though this represents an improvement since 2007, this is probably the result of a decline in the undocumented population rather than improvement in coverage rates of documented immigrants. The *Affordable Care Act* will significantly increase affordable health insurance and access to services for eligible immigrants starting in

2014. But undocumented persons are excluded from the expansion and since Mexicans account for over half of the undocumented population, they will unfortunately continue to make up a disproportionate share of the remaining uninsured population. Lacking health insurance is a leading barrier to seeking health services.

For those with health insurance, the type of coverage and use of services has changed little over the past ten years. Mexican and Central American immigrants are still more likely to be covered by public health programs in contrast with the non-Hispanic white population, the majority of whom enjoy private health insurance coverage, which is thought to offer more personalized and higher quality care. While Mexican immigrants were less likely in 2013 to lack a regular sources of care than in 2004 (37% and 42% respectively), these rates are still inequitable since the rate is double that of immigrants from other regions and triple the rate of non-Hispanic whites and African-Americans.

Despite experiencing more barriers than others in accessing health care, Mexican and Central American immigrants have lower rates of some chronic diseases compared to the African American and non-Hispanic white populations. Hispanics (both immigrants and native born) have lower rates of several of the most frequent causes of death in the US, including cardiovascular disease and cancer. They also have the longest life expectancy (81.4 years) of all of the groups studied. They are still disadvantaged however, in that they have the second highest rate of diabetes –after African Americans– which is a leading cause of death and an important public health issue in both the United States and Mexico. Given the increasing risk factors for diabetes in the Mexican origin population in the US addressing this issue is a priority.

Overall, the pattern of births for the Mexican immigrant population during the period of 2004 through 2011 reflects the dynamics occurring in other population groups of declining fertility, reflecting a convergence towards the reproductive pattern of the US and reflecting the declining fertility rates in Mexico as well. In the US, women in most immigrant and racial/ethnic groups are having fewer children, though the decline in fertility is taking place most rapidly among Mexican immigrants. Mexican families continue to be larger than others, but completed fertility is falling as Mexican women have reduced their likelihood of being young mothers and are starting their families at older ages. This may be beneficial in contributing to overall improved outcomes among infants. Mexican immigrant women are also following the trend of increasingly starting families while being unmarried, potentially signaling a shift in family structure.

It is our hope that this report contributes to framing the debate around equity in access to good health. With the growth and spreading of the Mexican origin population across the United States over the past ten years, preserving their health and wellbeing should be a top priority for policymakers. Legislation like the *Affordable Care Act* is a major step forward for improving health care equity, however, an effort must be made to find politically and socially acceptable mechanisms for also protecting the health of undocumented immigrants and other excluded groups.

Health is also related to social integration. Mechanisms that strengthen integration, such as acquiring American citizenship, which enables immigrants to exercise their rights and gain access to social and economic benefits, should be expanded. In addition, a more equitable balance in the labor market is needed that offers opportunity for skill development and advancement into higher wage occupations would help ease the concentration of Mexican and Central American immigrants in low-wage sectors. In addition, policy efforts to improve the minimum wage and establish "living wage" policies in many communities provide the prospect for improved incomes, health, and quality of life for the many low-waged Mexican immigrants.

Part of the wealth of the nation has historically been built on the social and economic contribution of immigrants. Health equity for immigrants is not only a basic human right but also an important element to sustain the social and economic benefits of immigration for sending and receiving societies. Mexican immigration to the US has been prominent over the past decade, no less so than in decades before. It is the health of these immigrants that will sustain the positive impact they have on the societies of origin and destination.

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